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

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

Order of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	Licensee Copy/Copie du Titulaire x **Public Copy/Copie Public**
Name of Director:	Brad Robinson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 X Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	Not Applicable
Original Inspection #:	Not Applicable
Licensee:	Corporation of the County of Simcoe 1110 Highway 26 Midhurst ON L9X 1N6
LTC Home:	Sunset Manor Home for Senior Citizens
Name of Administrator:	Sherry Bell

Background:

Sunset Manor Home for Senior Citizens ("the home") is a municipal long-term care home in Collingwood, Ontario within North Simcoe Muskoka Home and Community Care Support Services. The licensee, Corporation of the County of Simcoe ("the licensee") is licensed for 150 long-stay beds in the home.

From inspections conducted at the home between July 2018 to April 2021, several written notifications and compliance orders have been issued to the licensee for not complying with requirements under the *Long-Term Care Homes Act, 2007* ("Act") and Ontario Regulation 79/10 under the Act ("Regulation"). Despite these findings and orders, including a referral to the Director in September 2020, the licensee has not taken the necessary actions to bring itself into compliance with the Act and Regulation and sustain compliance. Accordingly, the licensee has demonstrated a lack of understanding of what is required to address non-compliance, sustain it, and operate the home in a manner that meets the requirements under the Act and Regulation.

Subsection 156(1) of the Act states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term

care home. Subsection 156(2) of the Act states that an order may be made under this section if: (a) the licensee has not complied with a requirement under the Act and (b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home or cannot do so without assistance.

The Director is issuing this Mandatory Management Order as the licensee has not complied with significant and, in some cases, recurring findings and orders of non-compliance under the Act. The licensee has been issued multiple compliance orders (often repeated) and has not taken the necessary actions to address and correct the serious issues of non-compliance. Further, there has been instability in the home's senior leadership as there has been frequent turnover in leadership positions which has not enabled the home to adopt and sustain corrective actions to ensure compliance. The non-compliance and orders directly impact resident care and safety and as such, the licensee's non-compliance with various requirements under the Act pose a risk of harm to residents. On June 10, 2021, the Director directed the placement co-ordinator to cease authorizing admissions to the home on the basis that there was a risk of harm to the health or well-being of residents of the home or persons who might be admitted as residents to the home. All of these reasons provide the Director with reasonable grounds to believe that the licensee cannot properly manage the home on its own. In addition, the Director has taken into account the factors under s. 299(1) of the Regulation in determining that this order is warranted.

Order:	

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:

Pursuant to: *Long Term Care Homes Act,* 2007 S.O. 2007, c.8 s 156 (1) ("Act"). The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Order: Corporation of the County of Simcoe ("the licensee") is ordered:

(a) to retain one or more persons, at your expense, described in paragraph (c) or (d) of this Order, to manage Sunset Manor Home for Senior Citizens located at 49 Raglan Street Collingwood ON L9Y 4X1 ("the home");

(b) to submit to the Director, Capital Planning Branch, a proposed person(s) described in paragraph (a) to this Order **within 14 calendar days** of being served with this Order;

(c) the person(s) described in paragraph (a) to this Order must be acceptable to the Director, Capital Planning Branch and approved by the Director, Capital Planning Branch, in writing;

(d) if the licensee does not submit a proposed person(s) described in paragraph (a) to this Order to the Director, Capital Planning Branch within the time period specified in paragraph (b) to this

Order, the Director, Capital Planning Branch will select the person(s) that the licensee must retain to manage the home;

(e) the person(s) described in paragraph (a) to this Order acceptable to the Director, Capital Planning Branch will have specific qualifications, including:

(i) the experience, skills and expertise required to operate and manage a long-term care (LTC) home in Ontario and to maintain compliance with the Act and Ontario Regulation 79/10 under the Act;

(ii) have a good Compliance Record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides consulting services has a compliance record under the Act that is considered to be Substantially Compliant including:

1. critical incidents that occur are reported as required;

2. complaints are managed effectively in the LTC home;

3. the LTC home develops policies/procedures using evidenced-based practice and quality strategies;

4. the LTC home responds to issues identified during inspections; and

5. non-compliance in areas of actual harm or high risk of harm to residents and any other persons identified during inspections are rectified within the time frame required by the inspector;

(iii) demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this order,

1. been declared bankrupt or made a voluntary assignment in bankruptcy;

2. made a proposal under any legislation relating to bankruptcy or insolvency; or

3. have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets;

(f) to submit to the Director, Capital Planning Branch, a written contract pursuant to section 110 of the Act **within 14 calendar days** of receiving approval of the Director, Capital Planning

Branch, pursuant to paragraph (c) of this Order or the selection of a person(s) pursuant to paragraph (d) of this Order;

(g) to execute the written contract **within 24 hours** of receiving approval of the written contract from the Director, Capital Planning Branch pursuant to section 110 of the Act and to deliver a copy of that contract once executed to the Director, Capital Planning Branch;

(h) to submit to the Director, LTC Inspections Branch, a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the home and that specifically addresses strategies and actions to achieve compliance with those areas identified as being in non-compliance **within 30 calendar days** of receiving approval of the Director, Capital Planning Branch, pursuant to paragraph (c) of this Order or the selection of a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director, Capital Planning Branch pursuant to paragraph (c) to this Order or selected by the Director, Capital Planning Branch pursuant to paragraph (d) of this Order, shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order **within 24 hours** of the execution of that written contract;

(j) the management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director;

(k) any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order; and

(l) Upon being served with this Order, comply with (a-k) and not take any actions that undermine or jeopardize the ability for the person approved by the Director, Capital Planning Branch pursuant to paragraph (c) to this Order or selected by the Director, Capital Planning Branch pursuant to paragraph (d) of this Order to manage the home to its full extent.

Grounds:
The licensee's non-compliance

The licensee has not complied with several requirements under the *Long-Term Care Homes Act,* 2007 and Ontario Regulation 79/10 under the Act. This Order relies on all inspection reports, non-compliance findings and orders issued from the following inspections conducted at the home:

Inspection No.	Inspection Report(s) Issued
2021_739694_0018	May 2021
2020_773155_0019	November 2020

2020_739694_0020	September 2020
2020_739694_0009	July 2020
2020_739694_0004	March 2020
2019_800532_0019	January 2020
2019_773155_0016	November 2019
2019_773155_0010	July 2019
2019_605213_0019	May 2019

Based on these inspections, below are significant areas of the licensee's non-compliance with requirements of the Act and Regulation, which have posed a risk of harm and well-being to residents in the home. A summary of some of the main compliance actions taken are addressed below.

Duty to protect residents re: Abuse and Neglect

Inspections have demonstrated that the licensee has failed to comply with s. 19(1) of the Act, as it did not protect residents from abuse and that residents were not neglected by the licensee or staff.

Inspection #2021_739694_0018 (conducted in April 2021)

- A compliance order was issued when a resident sustained an injury after another resident, with a history of physically responsive behaviours, caused physical pain / injury to the resident.
- A resident with a complex medical history, did not have the necessary monitoring for one of their chronic conditions over a ten-day period following admission to the home. The resident did not receive nutrition/hydration for a period of time during these ten days because of the staff's lack of understanding/training on the delivery of this type of nutrition/hydration. The lack of nutrition and hydration for this time period, combined with no monitoring of the chronic medical condition, put the resident at continued risk of harm. After the resident's death, a coroner's investigation identified that there was no process in place to monitor the resident's chronic medical condition.
- A resident with a deteriorating wound had specific treatment orders which did not include a specialized treatment. Despite the fact that there was no medical order, an RPN carried out this specialized treatment. The specialized treatment was outside the scope of practice for the RPN. Based on photographs of the wound pre and post treatment, there was significant change to the wound that would likely have impacted the resident's comfort level and quality of life.
- A physician assessed a resident at which time the resident said they had needed toileting but were told by staff earlier in the day that this was not possible. The resident had been advised by staff to go in their brief. The resident told the physician they felt intimidated and did not think it was too

much to ask to be toileted. The resident was not toileted, did not void or have a bowel movement throughout the day as they were afraid to soil themselves.

Inspection #2020_739694_0009 (conducted in May 2020)

- A compliance order was issued when a resident suffered injuries as a result of an altercation with another the resident. The resident that initiated the altercation had a history of physically responsive behaviours in response to specific triggers. Interventions were not in place to address these triggers and to prevent the ensuing altercation.

- A resident was approached a number of times by a staff member to engage in morning care. The resident did not wish to engage in the care. The staff member was both verbally and physically abusive towards the resident while trying to get them to engage in care. The incident resulted in both emotional and physical harm to the resident. The order was complied on September 8, 2020 during a follow-up inspection (#2020_739694_0020).

- A voluntary plan of correction was issued as a result of inspection #2019_800532_0019 conducted in December 2019. Staff failed to properly supervise a resident while providing care. During the absence of supervision, the resident was at serious risk of harm. Further, staff did not document nor report the incident and therefore, the resident was not medically assessed until two days later, only after the family raised concerns when the resident exhibited symptoms of concern.

- A written notification was issued as a result of inspection #2019_773155_0016 conducted in October 2019 as further evidence to support the compliance order issued during inspection 2019_773155_0010. The physician and family were not notified in a timely manner and interventions were not put in place to address a resident's bowel issues. The resident was transferred to hospital where they were admitted with a significant bowel diagnosis and other concerns.

- A written notification was issued as a result of inspection #2019_800532_0010 conducted in August 2019 as further evidence to support the compliance order issued during inspection #2019_773155_0010. A resident experienced a health condition over several months which required intermittent hospitalizations and treatment. The resident declined over a short period of time and required readmission to hospital. The physician was not notified when the resident's health status deteriorated, a pain assessment was not done when the resident exhibited signs and symptoms of pain. The resident's re-weigh was not completed even though the RD had requested it. There was failure to provide treatment and care from staff as required for the resident's health, safety and well-being.

- A compliance order was issued as a result of inspection #2019_773155_0010 conducted in May 2019. A substitute decision-maker of a resident was not notified of three separate unresponsive episodes by the resident. The physician was not notified of the episodes and did not assess the resident over a seven-day period when the resident experienced a change in health condition. The resident had an episode that required hospitalization and was diagnosed with a specified medical condition. Additionally, there was no action taken to identify, assess and implement interventions for the resident when there was decreased fluid intake and change in

hydration status. The compliance order was complied on October 4, 2019 during follow up inspection (#2019_773155_0014).

Skin and Wound Care

Inspections have demonstrated that the licensee has failed to comply with s. 50(2) of the Regulation, as it has not ensured that a skin assessment was completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for residents exhibiting altered skin integrity. The license also did not ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and that residents received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Inspection #2021_739694_0018 (conducted in April 2021)

- A compliance order was issued when a resident with an advanced wound did not receive the correct treatment. In addition, when there were signs of infection, an assessment and appropriate treatment was not provided. A staff member noted a change in the wound and asked that the wound be assessed. The assessment did not take place for four days at which point there were signs of infection and worsening of the wound. The physician was not notified at this time despite signs of an infection. The wound was not assessed, and an antibiotic prescribed until seven days after initial reports of potential wound infection. The resident's wound had worsened.

- A resident with a deteriorating wound had treatment provided by a registered staff that was not prescribed/ordered. The treatment provided was not within the scope of the staff member and resulted in a significant worsening of the wound. The treatment would have impacted the resident's comfort and quality of life.

- A resident sustained an injury to their skin which required treatment. Despite the skin condition having been assessed by a registered staff required follow-up treatment was not identified, completed or documented for approximately five months. There was a risk of infection and other complications as a result of the treatment not having been provided in a timely manner.

- During inspection #2020_773155_0019 completed in November 2020, a non-compliance finding under s. 50(2) Regulation was re-issued and a compliance order issued. A registered staff did not complete a skin assessment when a resident was readmitted from hospital. It was noted that the resident had multiple skin concerns. As a result, there may have been new areas of skin breakdown not identified and those already present may have worsened and not been monitored. The compliance order was determined to be complied with during inspection #2021_836766_0002 conducted in January 2021.

- During inspection #2020_739694_0020 completed in August 2020, a non-compliance finding under s. 50(2) Regulation was re-issued and a referral to the Director was made. A resident identified in a previous order had several skin concerns identified. Weekly skin/wound assessments for the identified skin concerns were either not done or incomplete with no measurements or descriptions. A second resident with two areas of altered skin integrity had a number of weekly assessments that were either not done or incomplete.

- During inspection #2019_773155_0016 completed in October 2019, a non-compliance finding under s. 50(2) was re-issued. A resident was re-admitted to the home from hospital after sustaining an injury. Upon return to the Home, a skin assessment was not completed, however, a registered staff noted the resident had a dressing in place. Treatment orders and a weekly skin assessment were not implemented and were not added to the resident's treatment administration record until 13 days after the resident returned to the home and when treatment had to be provided for a skin concern. In addition, a resident with a surgical wound did not have a weekly skin assessment completed; a resident with two separate areas of altered skin integrity did not have weekly skin assessments completed for several weeks; and a resident that had three separate wounds did not have weekly assessments completed for several weeks. In this case all three wounds worsened.

- A written notification was issued as a result of inspection #2019_773155_0010 conducted in May 2019 as further evidence to support the compliance order issued during inspection #2019_605213_0019. A resident who returned from hospital with a wound did not have weekly skin assessments completed and the resident was not assessed by a registered dietitian who was a member of the staff of the home.

- A compliance order was issued as a result of inspection #2019_605213_0019 conducted in May 2019. A resident returning from hospital with a wound did not receive an assessment for 20 days. Weekly wound assessments were not completed for this wound. Another resident sustained a skin injury that required treatment in hospital. An initial skin assessment was not completed upon return from hospital and there was no weekly assessment completed until more than three weeks later.

<u>Whistleblower Protections -- Discouraging disclosure of information to inspectors</u>

Inspections have demonstrated that the licensee has failed to comply with s. 26(5) of the act, As it has not ensured that management of the home did not take any actions that had the effect of discouraging staff members from disclosing information to an inspector during an inspection regarding resident care or operation of the home.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. Staff from a variety of program areas and departments in the home noted feeling intimidated and fearful to provide information to inspectors and/or the Director related to care concerns, abuse and neglect that occurred for fear of reprisal. Staff that did speak with inspectors shared they were interrogated afterwards by management and advised that they should not be providing information to inspectors unless absolutely necessary. Staff indicated that management advised staff that issues should be dealt with "in-house" and that inspectors used tactics to get information. This had the effect of staff being fearful to speak with inspectors and had the effect of discouraging staff to provide relevant information to inspectors during the inspection. Some staff asked to be spoken to offsite by inspectors because of fear of reprisal. Some staff wished to remain anonymous when providing information for fear of retaliation.

<u>Mandatory Reporting to the Director</u>

Inspections have demonstrated that the licensee has failed to comply with s. 24(1) of the Act, as it did immediately report to the Director information about potential improper care of a resident and abuse of a resident that resulted in harm or risk of harm to the resident.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. Two incidents, one related to alleged staff to resident abuse and one related to improper care were not reported to the Director immediately. In one case, the incident was not reported to the Director and was addressed by inspectors when in the home.

- A written notification was issued as a result of inspection #2020_739694_0004 conducted in February 2020. A resident's substitute decision-maker expressed their concerns in a meeting held at the home alleging on-going abuse of a resident by another resident. An e-mail was also sent to the home 9 days after the meeting with further concern of the alleged abuse. The Director was not notified until 10 days after the home was made aware of the alleged resident abuse.

- A compliance order was issued as a result of inspection #2019_773155_0010 conducted in May 2019. The home received allegations of neglect towards two residents. The home failed to immediately report the allegations to the Director until this issue was identified by an inspector. The compliance order was determined to be complied with on January 28, 2020 during follow up inspection #2019_773155_0016.

Altercations and other interactions between residents

Inspections have demonstrated that the licensee has failed to comply with s. 54(1) of the Regulation, as it did not ensure that interventions were implemented for residents demonstrating responsive behaviours to mitigate the risk of altercations and potentially harmful interactions among residents.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. Two residents had a history of altercations and there were strategies/interventions identified in their plans of care to minimize the risk of altercations. These strategies/interventions were not being implemented to address the altercation triggers and related responsive behaviours. In one situation, police had to be called to assist in de-escalating the situation to avoid injury.

- A voluntary plan of correction was issued as a result of inspection #2020_739694_0004 conducted in February 2020. A number of incidents occurred where a resident exhibited physically responsive behaviours towards another resident. Triggers were identified for the resident’s behaviours but interventions were not implemented to address these triggers and to prevent further altercations between these residents.

Nutrition and hydration programs

Inspections have demonstrated that the licensee has failed to comply with the requirements of s. 68(2) of the Regulation. This included the licensee not ensuring that the home’s nutrition and hydration programs included policies and procedures related to nutrition care and dietary services and hydration, and that the programs identified and mitigated risks related to nutrition care, dietary services and hydration.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. A resident at high nutritional risk receiving specialized feeding did not receive their nutrition/hydration for an extended period of time due to lack of staff understanding and knowledge of the specialized feeding process. Risks related to the resident’s medical condition and other

health changes were not taken into consideration when managing the resident. Specified monitoring was not carried out as per the physician's orders which put the resident at risk of harm.

- A compliance order was issued as a result of inspection #2019_773155_0016 conducted in October 2019. There were no referrals to the registered dietitian for three residents related to low fluid intake. They shared the expectation was that a referral to the RD was to be made when a resident had a fluid intake of less than seven glasses of water for three or more days. They also shared that registered staff were to assess the resident for signs and symptoms of dehydration and include the findings in the referral to the RD. There were no assessments of dehydration documented for these residents.

- A compliance order was issued as a result of inspection #2019_773155_0010 conducted in May 2019. 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. Fluid intake records identified that three residents did not consume adequate fluid intake however, there were no assessments completed nor interventions implemented. The nutrition care and hydration program did not identify any risks related to hydration status for residents and failed to implement interventions to mitigate and manage those risks for residents.

Administration of Drugs

Inspections have demonstrated that the licensee has failed to comply with s. 131(2) of the Regulation, as it did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. Three residents did not receive their high-risk medications, including narcotics, benzodiazepine and those used for Parkinson's disease, as prescribed. Concerns were identified with the transcription and processing of drug orders as well as the reporting of medication incidents.

- A voluntary plan of correction was issued as a result of inspection #2019_773155_0010 conducted in May 2019. A resident was not provided a medication at the prescribed time in accordance with the directions for use specified by the physician. On several occasions, the resident received the medication upwards of two to three hours after the prescribed time.

- A written notification was issued as a result of inspection #2019_605213_0019 conducted in May 2019. A resident did not receive medication as prescribed. It was not available with the resident's medication and it was unknown if the resident received an extra dose during the day shift.

Plan of Care

Inspections have demonstrated that the licensee has failed to comply with s. 6(1) of the LTCHA, as it did not ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provided direct care to the resident.

- A compliance order was issued as a result of inspection #2021_739694_0018 conducted in April 2021. A resident with an infection did not have a plan of care that provided clear direction in terms of the interventions to be implemented for infection prevention and control to front line care staff. Without clear direction in the plan of care, staff did not implement infection prevention and control measure which resulted in actual risk of transmission of the infection.

Licensee's inability to achieve and sustain compliance

A referral to the Director was made on September 8, 2020 by an inspector in relation to the third consecutive issuance of a compliance order for the licensee's non-compliance with s. 50(2) of the Regulation with respect to meeting skin and wound care requirements.

On October 29, 2020, the Director met with the licensee and the home's leadership in response to the Director's referral. During this call, the licensee and home outlined the steps and process changes that had been made to address the non-compliance and concerns that led to the referral to the Director.

Despite this meeting, a compliance order was re-issued for a fourth consecutive time during inspection #2020_773155_0019 conducted in November 2020 in relation to the licensee's non-compliance with s. 50(2) of the Regulation for failing to meet skin and wound care requirements. The compliance order was complied on January 18, 2021 and the Director's referral was closed. Although the licensee was able to bring itself into compliance, it is most concerning that within less than three months, multiple very serious issues related to the treatment and assessment of wounds were identified.

Further, the licensee has not been able to sustain compliance with respect to s. 19(1) of the Act and the prevention of resident abuse and neglect; s. 24(1) of the Act and mandatory reporting to the Director; and s. 68(2) of the Regulation and nutrition and hydration programs. Since May 2019, inspectors have issued non-compliance findings related to abuse and neglect of residents in the home six times, three of which were compliance orders and two were written notifications to support compliance orders issued; mandatory reporting to the Director three times, two of which were compliance orders; and nutrition and hydration programs three times, of which all three were compliance orders.

The repeated findings of non-compliance, including orders (in different areas), demonstrate that the licensee cannot take appropriate corrective action to achieve compliance and sustain it. It also demonstrates that the licensee lacks the required understanding of the actions to be taken to achieve and sustain compliance and operate the home in a manner that meets the requirements under the Act and Regulation.

On June 10, 2021, the Director directed the placement co-ordinator to cease authorizing admissions to the home on the basis that there was a risk of harm to the health or well-being of residents of the home or persons who might be admitted as residents to the home.

Management Instability

The home has had a history of frequent leadership turnover for the past three years. During this time, they have had three Directors of Care and three Assistant Directors of Care. The Executive Director has been in the home since the Fall of 2018 and recently went off on an extended leave. During previous inspections over the past few years, it was noted that the Executive Director had minimal presence in the resident

home areas and had very limited engagement with staff and inspectors. During the inspection, an Interim Executive Director from another long-term care home was present in the home.

These vacancies and turnover represent instability within the home at the management level. The instability and turnover contribute to the inability for senior leadership to provide direction and expertise to effectively understand the compliance issues, and correct them, and to manage/operate the home in accordance with the requirements under the Act and the Regulation. The home, despite internal supports provided by the licensee, have not created a culture of accountability and improvement with respect to compliance.

In addition to the above reasons, this Order is being issued based on the licensee's ongoing inability to maintain effective leadership in the home that is necessary to execute change and achieve compliance. Continued non-compliance puts residents' health, safety and quality of life at risk. Since July 2018 to May 2021, the home has had a total of 17 inspections resulting in 74 written notifications, 35 voluntary plans of correction, 23 compliance orders and 4 Director referrals.

Furthermore, the decision to issue this Director's Order is based on the scope and severity of non-compliance, and the licensee compliance history over the past 36 months. The scope of non-compliance is identified as widespread in the home and represents systemic failure that affects or has the potential to negatively affect many, if not all, of the home's residents. The severity of the non-compliance is determined to be actual harm or risk of actual harm. As noted in this Order, the licensee has a history of non-compliance findings with several requirements under the Act and Regulation. When taking all of the above information into account, there are reasonable grounds to believe that the licensee cannot or will not properly manage the home without assistance.

This order must be complied with by:	The dates as outlined and specified in the Order.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 10th day of June, 2021	
Signature of Director:	*Original Signed*

Name of Director:	Brad Robinson