Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2022	2022_673672_0004 (A1)	017227-21	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North Whitby ON L1R 3A5

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

An amendment was made to this report in order to correct a PSW number in an observation conducted related to meal services, within the Compliance Order related to s. 73 (1) 10.

Issued on this 12nd day of April, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 14, 15, 16, 18 and 22, 2022

A Critical Incident System inspection (#2021_673672_0005) was conducted

concurrently to this Follow Up Inspection. Findings of non-compliance were issued within that inspection report as well.

The following intake was completed during this Follow Up inspection:

One intake related to following up on a previous Director's Review which was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_875501_0021 on October 21, 2021, with a compliance due date of December 13, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Public Health Consultants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Recreation Aides (RAs), Physiotherapists (PT) and physio assistants (PTA), Dietary Aides (DAs), Housekeepers, Maintenance Workers, screeners and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Pain Management, Safe Food Handling and Serving Temperatures. The Inspector(s) also observed staff to resident and resident to resident care and interactions along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

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

- **1 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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 :

(A1)
1. The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Inspectors conducted resident observations during meal services. Due to the home experiencing a suspected COVID-19 outbreak, some residents in the home received meals via tray service. The lunch meal service started at approximately 1200 hours. On an identified date, Inspector noted that resident #014 had their meal served to them on their bedside table prior to a staff member being available to provide the required assistance. The meal consisted of soup, turkey, tomatoes and bread. At 1230 hours, the resident informed the Inspector that they were feeling very hungry and requested assistance with their meal. This was reported to PSW #127, who indicated they would assist the resident as soon as they were finished assisting resident #013 with their intake.

Inspector observed the resident was still waiting for assistance with their meal at 1238 hours therefore assessed the temperatures of each of the food items prior to the resident consuming the meal and noted the following:

Soup temperature - 55.4C
Entrée temperature – 17.2C
Vegetable temperature – 16.4C
Bread Temperature – 31.2C

Review of the internal policy related to food temperature control indicated the following required food temperatures for soup of 85C and whole turkey of 85C.

PSW #127 was not observed to offer to reheat resident #014's meal prior to it being served to the resident at 1243 hours, despite the meal sitting on the serving tray for almost 45 minutes.

During separate interviews, PSWs #105, #127 and RPN #104 indicated it was routine a practice in the home for meals to be served to residents in shared bedrooms who required assistance with their intake at the same time. This was to assist with saving time, so the same staff member could assist both residents without having to go back to the kitchenette to collect the second meal. The DOC indicated the expectation in the home was for meals to be served to residents only when the staff member was available to provide the required assistance with the meal, so that items were not left sitting out. The DOC further indicated this was to assist in ensuring all meals were served at both safe and palatable temperatures for the residents.

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; internal policy related to food temperature control; interviews with PSWs #105, #127, RPN #104 and the DOC. [s. 73. (1) 6.]

2. A Compliance Order (CO #001) was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_875501_0021 on October 21, 2021, with a compliance due date of December 13, 2021. A referral was sent to the Director on October 21, 2021, as the home was previously issued two compliance orders under s. 73 (1) 10 on February 12, 2021, within report #2021_715672_0004 and on April 16, 2021, within report #2021_595110_0004. A referral to the Director is being re-issued as follows:

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #008, #009, #011, #012, #013, #014 and #021, who each required assistance with eating.

Resident #008 was observed receiving assistance with their lunch meal from PSW #109. Resident #008 was noted to be slumping down and sliding forward from their seat while attempting to eat. This caused the resident to be in an unsafe position for intake. PSW #109 indicated staff had attempted to reposition resident #008 at the beginning of the meal, but the resident continued to slide down in their seat, therefore staff stopped attempting to reposition the resident. PSW #109 verified resident #008 was not in an upright position while they were attempting to eat and drink. On a later date, resident #008 was observed receiving assistance with their afternoon nourishment from PSW #120. Resident #008 was noted to be slumping down and sliding forward from their seat while consuming the items. This caused the resident to be in an unsafe position for intake. PSW #120 indicated staff had not attempted to reposition resident #008 prior to/during the nourishment, as resident #008 was “in their usual position”.

Resident #009 was observed receiving assistance with their lunch meal from Recreation Aide (RA) #118. Resident #009 was noted to be slumping down and sliding forward from their seat, causing the resident to have to lean forward significantly towards the table in order to sit upright to be able to eat and/or drink in a safe position. RA #118 verified resident #009 was in an unsafe position for intake and repositioned the resident with PSW assistance, which was effective in putting resident in a safe/upright position for further food/fluid intake.

Resident #011 was observed receiving assistance with their lunch meal from PSW #116. Resident #011 was noted to be slumping down and sliding forward from their seat while attempting to eat, which gave the appearance of the resident being tilted back significantly during food and fluid intake. PSW #116 verified resident #011 was sliding down in their seat, which was an unsafe position for intake, and repositioned the resident with assistance from another PSW. The repositioning was effective in putting resident #011 in a safe and upright position for further food/fluid intake.

Resident #012 was observed receiving assistance with their lunch meal while in their bedroom, from PSW #121. Resident #012 was noted to be tilted back in their mobility aide during food and fluid intake. PSW #121 indicated resident #012’s mobility aide was "tilted backwards all the time, including during meals",

due to identified reasons. PSW #121 was also observed assisting resident #012 with their intake while standing above the resident instead of being seated beside them.

Resident #013 was observed receiving assistance with their lunch meal while in bed, from PSW #133. Resident #013 was noted to be in a sitting position and eating at the side of their bed, but kept frequently leaning to their left side and/or laying down while eating/chewing/swallowing, due to not having any back support in their current position. PSW #133 indicated resident #013 was "tired and uncomfortable today" and "usually" ate in "either that position or in the bed with the head of the bed elevated to give the resident back support. PSW #133 verified resident #013 had no back support in the position they were in, which was not comfortable for the resident and verified resident #013 was in an unsafe position for food and fluid intake.

Resident #014 was observed receiving assistance with their lunch meal while in bed, from PSW #127, while the head of the bed was left in an almost flat position. PSW #127 verified resident #014 was in an unsafe position for intake, repositioned the resident and raised the head of the bed to an upright position. The repositioning was effective in putting resident #014 in a safe and upright position for further food/fluid intake.

Resident #021 was observed after being served their morning nourishment from PSW #127, of two full glasses of apple juice. Resident #021 was noted to be significantly tilted back in their mobility aide while drinking their juice. PSW #127 indicated resident #021’s mobility aide was always in that position for identified reasons. PSW #127 verified resident #021 should have been in an upright position during food and fluid intake, and then repositioned once the resident had consumed their nourishment.

During an interview, the DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #116, #120, #121, #127

and #133, RA #118 and the DOC. [s. 73. (1) 10.]

3. The licensee has failed to ensure that resident #014, who required assistance with eating and drinking, was not served their meal until someone was available to provide the assistance required by the resident.

On an identified date, at 1200 hours, Inspector noted that resident #014 had their meal served to them on their bedside table prior to a staff member being available to provide the required assistance. The meal consisted of soup, turkey, tomatoes and bread. At 1230 hours, the resident informed the Inspector that they were feeling very hungry and requested assistance with their meal. This was reported to PSW #127, who indicated they would assist the resident as soon as they were finished assisting resident #013 with their intake. PSW #127 arrived to assist resident #014 with their meal at 1243 hours.

During separate interviews, PSWs #105, #127 and RPN #104 indicated it was routine a practice in the home for meals to be served to residents in shared bedrooms who required assistance with their intake at the same time. This was to assist with saving time, so the same staff member could assist both residents without having to go back to the kitchenette to collect the second meal. The DOC indicated the expectation in the home was for meals to be served to residents only when the staff member was available to provide the required assistance with the meal.

By not ensuring residents who required assistance with eating and drinking were not served their meal until someone was available to provide the assistance required, there was a risk of the resident experiencing poor food/fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations conducted; interviews with PSWs #105, #127, RPN #104 and the DOC. [s. 73. (2) (b)]

Additional Required Actions:

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

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

(A1)
The following Voluntary Plan of Correction has been amended.

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 meals are served at both safe and palatable temperatures for the residents and are not served to residents until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 12nd day of April, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2022_673672_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017227-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 12, 2022(A1)
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Taunton Mills 3800 Brock Street North, Whitby, ON, L1R-3A5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Daniel Kennedy

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_875501_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Prepare, submit and implement a plan to ensure that proper techniques including safe positioning, are used to assist residents #008, #009, #011, #012, #013, #014 and #021, who each require assistance with eating. The plan must include the following:

a) an analysis of why the practice of assisting residents while in unsafe positioning during food and fluid intake is occurring.
b) steps to be taken to prevent the practice from occurring.
c) steps to be taken if the practice is observed.
d) consequences for staff who fail to comply with proper techniques to assist residents.
e) an auditing process to ensure that safe positioning of residents during meals is occurring.

Please submit the plan by April 5, 2022, for review to CentralEastSAO.MOH@ontario.ca, Attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

(A1)
1. A Compliance Order (CO #001) was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_875501_0021 on October 21, 2021, with a compliance due date of December 13, 2021. A referral was sent to the Director on October 21, 2021, as the home was previously issued two compliance orders under s. 73 (1) 10 on February 12, 2021, within report #2021_715672_0004 and on April 16, 2021, within report #2021_595110_0004. A referral to the Director is being re-issued as follows:

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #008, #009, #011, #012, #013, #014 and #021, who each required assistance with eating.

Resident #008 was observed receiving assistance with their lunch meal from PSW

#109. Resident #008 was noted to be slumping down and sliding forward from their seat while attempting to eat. This caused the resident to be in an unsafe position for intake. PSW #109 indicated staff had attempted to reposition resident #008 at the beginning of the meal, but the resident continued to slide down in their seat, therefore staff stopped attempting to reposition the resident. PSW #109 verified resident #008 was not in an upright position while they were attempting to eat and drink. On a later date, resident #008 was observed receiving assistance with their afternoon nourishment from PSW #120. Resident #008 was noted to be slumping down and sliding forward from their seat while consuming the items. This caused the resident to be in an unsafe position for intake. PSW #120 indicated staff had not attempted to reposition resident #008 prior to/during the nourishment, as resident #008 was "in their usual position".

Resident #009 was observed receiving assistance with their lunch meal from Recreation Aide (RA) #118. Resident #009 was noted to be slumping down and sliding forward from their seat, causing the resident to have to lean forward significantly towards the table in order to sit upright to be able to eat and/or drink in a safe position. RA #118 verified resident #009 was in an unsafe position for intake and repositioned the resident with PSW assistance, which was effective in putting resident in a safe/upright position for further food/fluid intake.

Resident #011 was observed receiving assistance with their lunch meal from PSW #116. Resident #011 was noted to be slumping down and sliding forward from their seat while attempting to eat, which gave the appearance of the resident being tilted back significantly during food and fluid intake. PSW #116 verified resident #011 was sliding down in their seat, which was an unsafe position for intake, and repositioned the resident with assistance from another PSW. The repositioning was effective in putting resident #011 in a safe and upright position for further food/fluid intake.

Resident #012 was observed receiving assistance with their lunch meal while in their bedroom, from PSW #121. Resident #012 was noted to be tilted back in their mobility aide during food and fluid intake. PSW #121 indicated resident #012's mobility aide was "tilted backwards all the time, including during meals", due to identified reasons. PSW #121 was also observed assisting resident #012 with their intake while standing above the resident instead of being seated beside them.

Resident #013 was observed receiving assistance with their lunch meal while in bed,

from PSW #133. Resident #013 was noted to be in a sitting position and eating at the side of their bed, but kept frequently leaning to their left side and/or laying down while eating/chewing/swallowing, due to not having any back support in their current position. PSW #133 indicated resident #013 was "tired and uncomfortable today" and "usually" ate in "either that position or in the bed with the head of the bed elevated to give the resident back support. PSW #133 verified resident #013 had no back support in the position they were in, which was not comfortable for the resident and verified resident #013 was in an unsafe position for food and fluid intake.

Resident #014 was observed receiving assistance with their lunch meal while in bed, from PSW #127, while the head of the bed was left in an almost flat position. PSW #127 verified resident #014 was in an unsafe position for intake, repositioned the resident and raised the head of the bed to an upright position. The repositioning was effective in putting resident #014 in a safe and upright position for further food/fluid intake.

Resident #021 was observed after being served their morning nourishment from PSW #127, of two full glasses of apple juice. Resident #021 was noted to be significantly tilted back in their mobility aide while drinking their juice. PSW #127 indicated resident #021's mobility aide was always in that position for identified reasons. PSW #127 verified resident #021 should have been in an upright position during food and fluid intake, and then repositioned once the resident had consumed their nourishment.

During an interview, the DOC indicated the expectation in the home was for staff members to be seated beside the resident while assisting with food intake and for all residents to be seated in a safe position during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; interviews with PSWs #116, #120, #121, #127 and #133, RA #118 and the DOC.

An order was made by taking the following factors into account:

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: A referral to the Director was issued to the licensee related to O. Reg. 79/10, s. 73 (1) 10 during Inspection #2021_875501_0021 on October 21, 2021, with a compliance due date of December 13, 2021. This was after a Compliance Order was issued to the licensee during Inspection #2021_715672_0004, on February 12, 2021, and a second Compliance Order was issued during Inspection #2021_595110_0004, on April 16, 2021. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 18, 2022

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 12nd day of April, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (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

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