Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 4, 2022	2022_678577_0002	016576-21, 020818-21, 021046-21	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Royal Oak Long Term Care Residence
1750 Division Road North Kingsville ON N9Y 4G7

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

DEBBIE WARPULA (577), PETER HANNABERG (721821)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 28, March 1 to 4, 2022.

The following intakes were inspected on during this Critical Incident System (CIS) inspection:
-one intake related to CIS #2939-000053-21, related to a resident fall with a fracture;
-one intake related to staffing; and
-one intake related to CIS #2939-000048-21, related to staff to resident neglect.

Complaint inspection #2022_678577_0003, was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), previous Director of Care (DOC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Staffing Clerk, Housekeeping Aide (HA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, abuse training records, employee files, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

5 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from neglect by two PSWs.

A Critical Incident System (CIS) report was received by the Director on an identified date, that alleged neglect of residents. The report did not indicate what the neglect entailed, how many residents were affected or the results of the investigation. The report indicated 'pending investigation'.

O. Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being of one or more residents.

A review of the home's policy "Abuse Allegations and Follow-Up -LTC-CA-WQ-100-05-02" effective June 8, 2021, indicated that the home had a zero tolerance for any form of resident abuse, as well as neglect. Their policy defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being of one or more residents.

Inspector #577 reviewed the investigation file, which contained an email on an identified date, from a PSW forwarded to the Administrator. The email alleged that they made observations of resident neglect at the beginning of their shift on an identified date and time, as follows:
- a resident had not received continence care and resulted in altered skin integrity; their bed was in a particular position;
- another resident had not received continence care;
- a resident was found sleeping in their specific mobility aid;
- another resident had not received continence care or hour of sleep (hs) care, the resident was wearing their clothes and not wearing their continent product, and sitting on

their assistive aid in their bathroom;
- a resident had not received continence care;
- another resident was sleeping in their bed in a particular position;
- a resident was in their chair in a particular position, without their specific treatment applied;
- another resident had not received continence care, and resulted in altered skin integrity;
- a resident had not received continence care;
- another resident had not received continence care, hs care was not done;
- a resident was found without their fall interventions in place;
- another resident had not received continence care and their bed was in a particular position;
- a resident was in their bed in a particular position;
- another resident was in their bed in a particular position; and
- a resident was wearing unclean clothing, their particular apparatus had not been emptied, they had altered skin integrity and the resident reported they only received pudding for a specific meal.

The investigation file also contained interview notes with three PSWs, conducted by the previous DOC. The investigation notes did not contain an outcome of the investigation.

Interview with a PSW, together with Inspector #577, reviewed their email which alleged resident neglect. They advised that no one had spoken to them about their concerns of resident neglect.

Interview with another PSW, advised that they had witnessed the neglectful care of the residents on a particular shift on an identified date, specifically residents had not received continence care, beds were found in a particular position, and one resident had not received their meal on that shift. They recalled assisting a PSW with residents on that particular shift. Stated “It was really bad”.

Interview with the previous DOC, they advised that their investigation entailed speaking with three PSWs, and stated that they felt that the allegations of resident neglect weren't accurate. Advised that they had not spoken with the PSW who had reported the alleged neglect; they had not spoken with the residents; they didn’t recall any further documentation concerning the outcome of the investigation; they didn’t amend the CIS report or notify any resident POA’s of the alleged neglect.

Sources: Critical Incident System (CIS) report, the home's policy Abuse Allegations and

Follow-Up (LTC-CA-WQ-100-05-02 effective June 8, 2021), abuse training records, interview notes, investigation file, interviews with the previous DOC and other staff. [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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the previous DOC complied with the home's zero tolerance of abuse and neglect of resident’s policy in regard to investigating neglect of residents.

A CIS report was received by the Director on an identified date that alleged neglect of residents. The report did not indicate what the neglect entailed or the results of the investigation. The report indicated ‘pending investigation’.

A review of the home’s policy “Investigations – LTC-CA-WQ-100-05-01” effective May 2017, indicated the following:
-critical incidents, resident abuse and written complaints require investigation
-the supervisor/manager receiving the information would obtain information from the person reporting the issue
-the supervisor/manager would obtain written statements from all involved and from witnesses
-a comprehensive investigation would be undertaken using the home’s specific “Investigation Form”
-the supervisor/manager were required to write a written report the day the investigation was completed, which included written statements, a summary of notes of verbal statements, the conclusion and rationale and the current condition of the resident, and
-investigations with a written report of the outcome would be completed within ten working days of receiving the report.

Review of the home’s investigation contained interview notes with three PSWs conducted by the previous DOC.

The DOC and Administrator could not provide any documentation concerning the outcome, written report, written statements, or an investigation form from the previous DOC who was responsible for the investigation.

Sources: CIS report, the home's policy Investigations (LTC-CA-WQ-100-05-01 effective May 2017), abuse training records, interview notes, investigation file, interviews with the DOC and other staff. [s. 20. (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 staff comply with the home's zero tolerance of abuse and neglect of resident's policy in regard to investigating neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing services referred to in Ontario Regulation 79/10, s. 31 (1) (a) and (b).

Inspector #577 reviewed a document “Chartwell Royal Oak Staffing Plan” provided by the DOC, which identified that the home did not have a staffing plan in place for Registered Practical Nurses (RPNs) and Registered Nurses (RNs) that met the legislative requirements. The plan included a back up plan for all staff and a description of required staffing for PSWs per shift and per neighborhood.

During an interview with the DOC, they were not able to provide the Inspector with the home’s written staffing plan for registered staff referred to in Ontario Regulation 79/10, s. 31 (2).

The DOC acknowledged that the home did not have a written staffing plan in place for registered staff that met the requirements for a staffing plan as identified in O. Reg. 79/10, s. 31 (3) including:
- providing for a staffing mix that was consistent with residents’ assessed care and safety needs and that met the requirements set out in the Act and Regulation; and
- setting out the organization and scheduling of staff shifts, for registered staff.

Sources: the home's policy Chartwell Royal Oak Staffing Plan and an interview with the DOC. [s. 31. (3) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was received by the Director on an identified date, which alleged neglect of residents. The report indicated that the resident's substitute decision-makers weren't notified.

Review of the home's policy "Abuse Allegations and Follow-Up – LTC-CA-WQ-100-05-02", effective June 8, 2021, indicated that the Administrator or DOC was responsible to immediately notify the family/Substitute Decision Maker (SDM) and /or Power of Attorney (POA) when there was alleged neglect that resulted in injury, pain, distress, or was detrimental to the residents' health.

During an interview with the previous DOC, they advised that they had not notified any of the resident's substitute decision makers of the allegations of neglect of multiple residents.

Sources: CIS report, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective June 8, 2021), and an interview with the previous DOC. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include the description of the incident in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged neglect of multiple residents.

A CIS report was received by the Director on an identified date, that alleged neglect of residents. The report did not include a description of the neglect and indicated that three PSWs were off on administrative leave pending investigation.

Review of the home's policy "Critical Incidents/Reportable Incidents – LTC-CA-WQ-100-05-04", effective June 8, 2021, indicated that the DOC/Administrator or designate was responsible to update and complete the on-line critical incident report and ensure that all areas of the report were completed for the Ministry of Long Term Care, and must be completed within ten days of the date of the incident.

Interview with the ADOC, advised that they submitted the CIS report and the previous DOC was responsible for the amendments, as they had done the investigation.

Sources: CIS report, the home's policy Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective June 8, 2021), and an interview with the ADOC. [s. 104. (1) 1.]

2. The licensee has failed to include the names of all residents in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged neglect of residents.

A CIS report was received by the Director on an identified date, that alleged neglect of residents. The report did not indicate any resident names.

A review of the home's policy "Critical Incidents/Reportable Incidents – LTC-CA-WQ-100-05-04", effective October 2019, indicated that the DOC or designate was responsible to update and complete the on-line critical incident report and ensure that all areas of the report were completed for the Ministry of Long Term Care, and must be completed within ten days of the date of the incident.

Sources: CIS report, the home's policy Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective June 8, 2021), and an interview with the ADOC. [s. 104. (1) 2. i.]

3. The licensee has failed to include the care or action taken in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged neglect of residents.

A CIS report was received by the Director on an identified date, that alleged neglect of residents. The report indicated 'pending investigation' under the category of care or action taken.

A review of the home's policy "Critical Incidents/Reportable Incidents – LTC-CA-WQ-100-05-04", effective October 2019, indicated that the DOC or designate was responsible to update and complete the on-line critical incident report and ensure that all areas of the report were completed for the Ministry of Long Term Care, and must be completed within ten days of the date of the incident.

Sources: CIS report, the home's policy Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective June 8, 2021), and an interview with the ADOC. [s. 104. (1) 3. i.]

4. The licensee has failed to include the outcome in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged neglect of multiple residents.

A CIS report was received by the Director on an identified date, that alleged neglect of residents. The report indicated 'pending investigation' under the outcome category.

A review of the home's policy "Critical Incidents/Reportable Incidents – LTC-CA-WQ-100-05-04", effective October 2019, indicated that the DOC or designate was responsible to update and complete the on-line critical incident report and ensure that all areas of the report were completed for the Ministry of Long Term Care, and must be completed within ten days of the date of the incident.

Sources: CIS report, the home's policy Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective June 8, 2021), and an interview with the ADOC. [s. 104. (1) 3. v.]

5. The licensee has failed to include the long-term actions planned to correct the situation and prevent recurrence in making a report to the Director under subsection 23(2) of the Act, with respect to the alleged neglect of multiple residents.

A CIS report was received by the Director on an identified date, that alleged neglect of residents. The report indicated ‘pending investigation’ under the long-term actions planned category.

A review of the home’s policy “Critical Incidents/Reportable Incidents – LTC-CA-WQ-100-05-04”, effective October 2019, indicated that the DOC or designate would fully investigate the critical/reportable incident having developed long term actions to implement to minimize the likelihood of recurrence.

Sources: CIS report, the home's policy Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective June 8, 2021), and an interview with the ADOC. [s. 104. (1) 4. ii.]

Issued on this 22nd day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DEBBIE WARPULA (577), PETER HANNABERG (721821)
Inspection No. / No de l’inspection :	2022_678577_0002
Log No. / No de registre :	016576-21, 020818-21, 021046-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 4, 2022
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Royal Oak Long Term Care Residence 1750 Division Road North, Kingsville, ON, N9Y-4G7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lisa Smith

To Chartwell Master Care LP, 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

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 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 O. Reg. 79/10.

Specifically the licensee must:
a) Ensure all residents are protected from abuse and neglect
b) Ensure that every alleged, suspected or witnessed incident of abuse and neglect of a resident is investigated, as per the home's investigation policy
c) Ensure that appropriate action is taken in response to every every alleged, suspected or witnessed incident of abuse and neglect of a resident
d) Ensure that the documentation for Critical Incident System (CIS) reports submitted related to abuse and neglect includes a description of the incident, name of resident(s), notification of resident's Substitute decision-maker, care or action taken, the outcome and long term actions to prevent a recurrence.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were protected from neglect by two PSWs.

A Critical Incident System (CIS) report was received by the Director on an identified date, that alleged neglect of residents. The report did not indicate what the neglect entailed, how many residents were affected or the results of the investigation. The report indicated 'pending investigation'.

O. Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being of one or more residents.

A review of the home's policy "Abuse Allegations and Follow-Up -LTC-CA-

WQ-100-05-02" effective June 8, 2021, indicated that the home had a zero tolerance for any form of resident abuse, as well as neglect. Their policy defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being of one or more residents.

Inspector #577 reviewed the investigation file, which contained an email on an identified date, from a PSW forwarded to the Administrator. The email alleged that they made observations of resident neglect at the beginning of their shift on an identified date and time, as follows:
- a resident had not received continence care and resulted in altered skin integrity; their bed was in a particular position;
- another resident had not received continence care;
- a resident was found sleeping in their specific mobility aid;
- another resident had not received continence care or hour of sleep (hs) care, the resident was wearing their clothes and not wearing their continent product, and sitting on their assistive aid in their bathroom;
- a resident had not received continence care;
- another resident was sleeping in their bed in a particular position;
- a resident was in their chair in a particular position, without their specific treatment applied;
- another resident had not received continence care, and resulted in altered skin integrity;
- a resident had not received continence care;
- another resident had not received continence care, hs care was not done;
- a resident was found without their fall interventions in place;
- another resident had not received continence care and their bed was in a particular position;
- a resident was in their bed in a particular position;
- another resident was in their bed in a particular position; and
- a resident was wearing unclean clothing, their particular apparatus had not been emptied, they had altered skin integrity and the resident reported they only received pudding for a specific meal.

The investigation file also contained interview notes with three PSWs, conducted by the previous DOC. The investigation notes did not contain an outcome of the investigation.

Interview with a PSW, together with Inspector #577, reviewed their email which alleged resident neglect. They advised that no one had spoken to them about their concerns of resident neglect.

Interview with another PSW, advised that they had witnessed the neglectful care of the residents on a particular shift on an identified date, specifically residents had not received continence care, beds were found in a particular position, and one resident had not received their meal on that shift. They recalled assisting a PSW with residents on that particular shift. Stated "It was really bad".

Interview with the previous DOC, they advised that their investigation entailed speaking with three PSWs, and stated that they felt that the allegations of resident neglect weren't accurate. Advised that they had not spoken with the PSW who had reported the alleged neglect; they had not spoken with the residents; they didn't recall any further documentation concerning the outcome of the investigation; they didn't amend the CIS report or notify any resident POA's of the alleged neglect.

Sources: Critical Incident System (CIS) report, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective June 8, 2021), abuse training records, interview notes, investigation file, interviews with the previous DOC and other staff. [s. 19. (1)]

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

Severity: There was minimal harm or minimal risk

Scope: The scope of this non-compliance was a pattern, as it affected 13 residents

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(577)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 13, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 4th day of April, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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