Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_805638_0026 (A2)	020587-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 6G3

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

Amended by KEARA CRONIN (759) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The home has requested, and been granted, an extension to the compliance due date so that sustainable compliance can be achieved.

Issued on this 13th day of December, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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Long-Term Care Inspections Branch

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Extendicare Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 6G3

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

Amended by KEARA CRONIN (759) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 19 - 22, 2019.

The following intake was completed in this complaint inspection:

-One log which was related to a complaint submitted to the Director regarding alleged neglect and improper care.

A critical incident system inspection #2019_828759_0004, was conducted concurrently with this complaint inspection.

Inspector, Keara Cronin (759) and Michelle Berardi (679) attended this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, internal investigation notes and resident health care records.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **4 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 resident #004 was protected from neglect by the staff.

Neglect is defined in the O.Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or

well-being of one or more residents

A complaint was submitted to the Director related to alleged neglect and improper care which resulted in significant altered skin integrity. The complaint identified that resident #004 required specific interventions to prevent skin breakdown due to a specific diagnoses, which had not occurred and indicated they felt the resident was neglected and staff were not properly caring for the resident.

A) Inspector #638 reviewed resident #004's health care records and identified in the progress notes that the resident was noted to have an area of altered skin integrity to a specific area due to their specific diagnoses on a specific date. The next progress note on the area occurred 13 days later. The notation identified that the resident had two areas of altered skin integrity which due to their specific diagnoses. The Inspector noted a third notation 15 days after the second notation that the RN was notified regarding the two areas of altered skin integrity which had worsened since the first notation.

Inspector #638 interviewed RPN #111 (skin and wound lead), who indicated that direct care staff monitored skin integrity and reported new concerns to registered staff to assess and determine treatment. The Inspector reviewed the three aforementioned progress notes and the RPN indicated that the areas of altered skin integrity should not have gotten that far without any assessment or intervention in place.

The resident went 28 days since the identification of the initial identification of the area of altered skin integrity before the area was assessed and treatment was initiated. The Inspector reviewed resident #004's progress notes and identified a notation created by NP #116, which stated that the area may be difficult to heal due to their specific diagnoses. A follow up progress note was created by NP #116, which indicated that the area of altered skin integrity had progressed which posed a high risk to the resident.

B) Section 6 subsection 9 of the LTCHA, 2007, stipulates that the provision of the care set out in the plan of care is documented.

Inspector #638 reviewed resident #004's health care records and identified in their care plan a foci related to impaired skin integrity related to a specific diagnoses. The intervention directed staff to ensure that they would monitor skin daily and ensure that a specific device was implemented to prevent skin breakdown at all

times.

Inspector #638 reviewed resident #004's health care records over a one month period, and was unable to identify any documentation to support that direct care staff ensured that the specific intervention was implemented at all times.

In an interview with the DOC, the Inspector inquired how staff documented the provision of care set out in the plan of care. The DOC indicated that PSWs used Point of Care for their charting and registered staff had access to the progress notes. When asked how staff knew who was responsible for ensuring the specific intervention was implemented at all times, the DOC indicated that it was the PSWs responsibility, but it wasn't a specific task that was in place. The DOC indicated, in hindsight, staff should have documented the provision of the care as they were unsure of who had checked to ensure the specific intervention was implemented.

C) Section 24 subsection 1 of the LTCHA, 2007, stipulates that a person who has reasonable grounds to suspect that neglect and improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of the complaint identified that the complainant indicated they had alleged neglect and improper care to ADOC #114 on a specific date.

During an interview with Inspector #638, the complainant identified that they had specifically alleged neglectful care when they brought their concerns forward to ADOC #114. Please see WN #3 for details.

D) Inspector #638 identified a progress note created by NP #116 on a specific date, which stated they recommended a specific pharmaceutical intervention prior to wound care due to the resident having increased pain during care. The Inspector identified a second progress note created by NP #116 five days later, which stated resident experienced pain during wound care and their pharmaceutical intervention had not been signed for and therefore it had not been used prior to the specific wound care intervention. Please see WN #4 for details.

The Inspector reviewed the electronic treatment administration records (eTAR)

and identified that registered staff completed the daily dressing changes each day between the two NP's notations. The Inspector then reviewed the electronic medication administration records (eMAR) and noted that the pharmaceutical intervention had not been administered prior to the wound care as it was ordered.

In an interview with Inspector #638, the DOC indicated that as soon as management became aware of resident #004's areas of altered skin integrity, they immediately initiated treatment. The Inspector reviewed their aforementioned findings and series of events that transpired prior to their identification of the area and inquired if the DOC felt that this was considered neglectful care. The DOC indicated when it was put all together like this, it looks that way and that they considered these incidents a pattern of inaction. [s. 19. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A complaint was submitted to the Director related to alleged neglect and improper care which resulted in altered skin integrity. The complaint identified that resident #004 required specific interventions to prevent skin breakdown due to a specific health condition and that those interventions had not occurred. Please see WN #1 for details.

Inspector #638 reviewed resident #004's health care records and identified in the progress notes that the resident was noted to have an area of altered skin integrity to a specific area due to their specific diagnoses on a specific date. The next progress note on the area occurred 13 days later. The notation identified that the resident had two areas of altered skin integrity which due to their specific diagnoses. The Inspector noted a third notation 15 days after the second notation that the RN was notified regarding the two areas of altered skin integrity which had worsened since the first notation.

Upon reviewing resident #004's assessment records, the Inspector noted the first

assessment on resident #004's area of altered skin integrity occurred 28 days after the area of altered skin integrity had been initially identified.

In an interview with Inspector #638, PSW #106 indicated that they monitored resident skin integrity during care and reported any changes to registered staff upon identifying them. The PSW indicated the registered staff would assess and determine interventions; however, the PSWs would continue to monitor for any further changes in skin integrity until it healed.

During an interview with Inspector #638, RPN #108 indicated that any open area or even a reddened area would qualify as an area of altered skin integrity. The RPN indicated that upon becoming aware of an area of altered skin integrity, they would assess the wound using their assessment tool in Point Click Care (PCC) assessments, determine treatment and update the care plan right away.

Inspector #638 interviewed RPN #111 (skin and wound lead), who indicated that direct care staff monitored skin integrity and reported new concerns to registered staff to assess and determine treatment. The RPN indicated anything that was abnormal for the resident, including bruising, ulcers, blisters and reddened areas would be considered an area of altered skin integrity and required action. The Inspector reviewed the three aforementioned progress notes and resident #004's health care records with the RPN. The RPN indicated that when the first reddened area was identified registered staff should have assessed the area, initiated a treatment and follow up assessments weekly. The RPN stated that the areas of altered skin integrity ended up being a significant wound and should not have gotten that far without anything in place.

The home's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02" last updated August 2019, indicated that the nurse or wound care lead was to promptly assess all residents exhibiting altered skin integrity on initial discovery using the clinically appropriate assessment tool.

During an interview with Inspector #638, the DOC indicated that altered skin integrity included reddened areas, bruises, skin tears or anything that effected the resident's normal skin integrity. Upon reviewing the aforementioned progress notes with the DOC, they indicated that staff should have assessed resident #004's reddened area and put in for a weekly assessment when it was first identified. [s. 50. (2) (b) (i)]

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 any resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of improper or incompetent treatment or care of a resident that resulted in harm to the resident were reported to the Director.

A complaint was submitted to the Director related to alleged neglect and improper care which resulted in altered skin integrity. The complaint identified that resident #004 required specific interventions to prevent skin breakdown due to a specific diagnoses, which was not occurring and indicated they had alleged neglect and improper care to ADOC #114 on a specific date.

During an interview with Inspector #638, the complainant identified that they had specifically alleged neglectful care when they brought their concerns forward to ADOC #114.

Inspector #638 reviewed the Long-Term Care Home reporting portal and was unable to identify any critical incident form submitted related to the complainant's allegations of neglect related to resident #004's care.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02" last revised June 2019, indicated that management will promptly and objectively report all incidents to external regulatory authorities.

In an interview with Inspector #638, ADOC #114 indicated that they received the complaint regarding resident #004. They indicated that all the issues identified were reviewed and resolved with appropriate follow up from the home to the complainant. The ADOC indicated the complainant stated that they felt that the care could have been managed better. When asked if the complainant identified neglect as part of their concerns, the ADOC indicated the word may have been used at some point but after discussion with management, there was uncertainty surrounding reportability; a decision was made to treat the incident as a complaint related to care. [s. 24. (1) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #638 identified a progress note created by NP #116 on a specific date which directed staff to administer a specific pharmaceutical intervention prior to providing specific care as the resident experienced pain.

The Inspector reviewed the resident's orders and identified a specific pharmaceutical intervention to be administered a specific amount of time prior to providing the resident with their scheduled wound care.

The Inspector identified a second progress note created by NP #116 five days later, which stated resident experienced pain during wound care and their pharmaceutical intervention had not been signed for and therefore not been used prior to the specific wound care intervention.

The Inspector reviewed the electronic treatment administration records eTAR and identified that registered staff completed the daily dressing changes each day between the two progress notes by NP #116. The Inspector then reviewed the eMAR between these dates and noted that the medication had not been administered prior to the daily wound care. [s. 131. (2)]

Issued on this 13th day of December, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KEARA CRONIN (759) - (A2)
Inspection No. / No de l'inspection :	2019_805638_0026 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	020587-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2019(A2)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Maple View of Sault Ste. Marie 650 Northern Avenue, SAULT STE. MARIE, ON, P6B-6G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee must:

a) ensure that action is taken upon the identification of any new area of altered skin integrity to ensure immediate action is taken to prevent worsening of the area;

b) document and maintain a record of the implementation and monitoring of pressure relieving devices for residents at risk of skin breakdown; and

c) immediately report allegations of improper care or neglect and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004 was protected from neglect by the staff.

Neglect is defined in the O.Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

A complaint was submitted to the Director related to alleged neglect and improper care which resulted in significant altered skin integrity. The complaint identified that

resident #004 required specific interventions to prevent skin breakdown due to a specific diagnoses, which had not occurred and indicated they felt the resident was neglected and staff were not properly caring for the resident.

A) Inspector #638 reviewed resident #004's health care records and identified in the progress notes that the resident was noted to have an area of altered skin integrity to a specific area due to their specific diagnoses on a specific date. The next progress note on the area occurred 13 days later. The notation identified that the resident had two areas of altered skin integrity which due to their specific diagnoses. The Inspector noted a third notation 15 days after the second notation that the RN was notified regarding the two areas of altered skin integrity which had worsened since the first notation.

Inspector #638 interviewed RPN #111 (skin and wound lead), who indicated that direct care staff monitored skin integrity and reported new concerns to registered staff to assess and determine treatment. The Inspector reviewed the three aforementioned progress notes and the RPN indicated that the areas of altered skin integrity should not have gotten that far without any assessment or intervention in place.

The resident went 28 days since the identification of the initial identification of the area of altered skin integrity before the area was assessed and treatment was initiated. The Inspector reviewed resident #004's progress notes and identified a notation created by NP #116, which stated that the area may be difficult to heal due to their specific diagnoses. A follow up progress note was created by NP #116, which indicated that the area of altered skin integrity had progressed which posed a high risk to the resident.

B) Section 6 subsection 9 of the LTCHA, 2007, stipulates that the provision of the care set out in the plan of care is documented.

Inspector #638 reviewed resident #004's health care records and identified in their care plan a foci related to impaired skin integrity related to a specific diagnoses. The intervention directed staff to ensure that they would monitor skin daily and ensure that a specific device was implemented to prevent skin breakdown at all times.

Inspector #638 reviewed resident #004's health care records over a one month

period, and was unable to identify any documentation to support that direct care staff ensured that the specific intervention was implemented at all times.

In an interview with the DOC, the Inspector inquired how staff documented the provision of care set out in the plan of care. The DOC indicated that PSWs used Point of Care for their charting and registered staff had access to the progress notes. When asked how staff knew who was responsible for ensuring the specific intervention was implemented at all times, the DOC indicated that it was the PSWs responsibility, but it wasn't a specific task that was in place. The DOC indicated, in hindsight, staff should have documented the provision of the care as they were unsure of who had checked to ensure the specific intervention was implemented.

C) Section 24 subsection 1 of the LTCHA, 2007, stipulates that a person who has reasonable grounds to suspect that neglect and improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of the complaint identified that the complainant indicated they had alleged neglect and improper care to ADOC #114 on a specific date.

During an interview with Inspector #638, the complainant identified that they had specifically alleged neglectful care when they brought their concerns forward to ADOC #114. Please see WN #3 for details.

D) Inspector #638 identified a progress note created by NP #116 on a specific date, which stated they recommended a specific pharmaceutical intervention prior to wound care due to the resident having increased pain during care. The Inspector identified a second progress note created by NP #116 five days later, which stated resident experienced pain during wound care and their pharmaceutical intervention had not been signed for and therefore it had not been used prior to the specific wound care intervention. Please see WN #4 for details.

The Inspector reviewed the electronic treatment administration records (eTAR) and identified that registered staff completed the daily dressing changes each day between the two NP's notations. The Inspector then reviewed the electronic medication administration records (eMAR) and noted that the pharmaceutical

intervention had not been administered prior to the wound care as it was ordered.

In an interview with Inspector #638, the DOC indicated that as soon as management became aware of resident #004's areas of altered skin integrity, they immediately initiated treatment. The Inspector reviewed their aforementioned findings and series of events that transpired prior to their identification of the area and inquired if the DOC felt that this was considered neglectful care. The DOC indicated when it was put all together like this, it looks that way and that they considered these incidents a pattern of inaction.

The severity of this issue was determined to be a level three, as there was actual harm to resident #004. The scope of the issue was isolated, as it was identified to have impacted one resident in the home. The home had a level four compliance history, as they had previous non-compliance in the previous 36 months within this section of the LTCHA, 2007, which included;
-one compliance order from inspection #2019_776613_0018, issued July 4, 2019;
-one compliance order with a director referral from inspection #2018_668543_0020, issued October 23, 2018;
-one compliance order from inspection #2018_616542_0010, issued June 7, 2018; and
-one compliance order from inspection #2016_562620_0030, issued February 24, 2017. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A2)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 13th day of December, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KEARA CRONIN (759) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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