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
Jan 31, 2022	2021_595110_0014 (A1)	013183-21, 017794-21, 018612-21	Critical Incident System

Licensee/Titulaire de permis

Tendercare Nursing Homes Limited
20 High Park Blvd. Toronto ON M6R 1M7

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

Tendercare Living Centre
1020 McNicoll Avenue Scarborough ON M1W 2J6

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

Amended by DIANE BROWN (110) - (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

This report has been amended to reflect an extension of the compliance due date from January 31, 2022 to March 2, 2022 at the request of the licensee.

Issued on this 31st day of January, 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

Long-Term Care Operations Division
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
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Tendercare Living Centre
1020 McNicoll Avenue Scarborough ON M1W 2J6

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

Amended by DIANE BROWN (110) - (A1)

Amended 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): November 25, 26, 29, 30, 2021. December 1, 2021.

Three Critical Incidents (CIs) logs #013183-21, #017794-21 and #018612-21 were inspected all related to resident falls resulting in a transfer to hospital and significant change in their health status.

Infection Prevention and Control Inspection was also completed.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Manager of Environmental Services, maintenance worker, Physiotherapists, Registered Nurses, Registered Practical Nurses, Personal Support Workers.

During the course of this inspection, the Inspector toured resident home areas, observed residents, shower chairs, fall prevention equipment and infection control practices . Reviewed clinical health records, Daily Nursing reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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

3 WN(s)
1 VPC(s)
2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 70/10, s. 48(1)1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The Homes' 'Fall Prevention and Management Policy' including the Post Fall Clinical Pathway directs the registered nurse to notify the physician after a fall with injury and assess the resident for anticoagulant use.

Resident #001 had an unwitnessed fall and when assessed had sustained an injury.

The resident's medications included a medication that interfered with blood clotting. The resident was given this medication on the day of the fall.

An interview with the responding RN stated they were unaware the resident was taking the identified medication at the time of the fall and confirmed that they should have notified the physician of the resident's fall and injury.

The resident was transferred to hospital, diagnosed with a condition complicated by the lack of blood clotting and passed away.

Sources: final discharge summary, medication administration records, post fall assessment, progress notes, written care plan. Staff interviews with RN #104, PSW #108 and DOC #105. [s. 8. (1)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting

resident #002's fall resulting in a transfer to hospital and subsequent death.

Resident #002 was familiar to the staff, retuning to the home from a prior discharge.

The physiotherapists admission assessment, day one in the home, identified a specific mobility aide (A) as the resident's primary mode of locomotion; that the resident was at risk for falls and required an extensive two person assistance for all transfers.

The 24 hour(hr) plan of care identified the resident as requiring a different mobility aide (B) and one staff to provide assistance with transfers.

The resident was provided with mobility aide (B) by their bedside and found on the floor by between the end of their bed and washroom. The resident was transferred to the hospital, diagnosed with significant injury and later passed away.

Registered staff identified that the resident's prior care plan was used to guide the new admission and the 24hr care plan. Staff interviews reported that the resident had declined since being discharged and that mobility aide B and one person assistance was no longer appropriate and the PT assessment should have been referenced in the 24 hr care plan.

The licensee failed to ensure nursing staff collaborate with PT in the development of the 24 hr care plan.

Sources: 24hr care plan, progress notes, PT assessments, Interviews with PSW #114, #117, RPN #118 and #119 and the nurse practitioner. [s. 6. (4) (a)]

2. The licensee failed to ensure the care set out in the plan of care provided to the resident as specified in the plan.

A CI was submitted to the Ministry of Long-Term Care reporting resident #001's fall resulting in a significant change of status and subsequent death.

On the night of the resident's fall PSW #107 stated the resident independently left the dining room with their mobility aide and RN #104 found the resident on the floor, in their room, while administering medications in the area. The resident was

on the floor by the resident's washroom, presumedly, according to the RN, waiting to use the washroom as it was occupied.

The resident's plan of care identified one staff assistance for mobility, transfers and toileting assistance for safety. The licensee failed to ensure the care set out in the plan of care provided to the resident as specified in the plan.

Sources: Interviews with PSW #100, #101, #102, #103, #107, #108, RN #104. Written plan of care and health record including progress notes and Post Fall Assessments for four falls. [s. 6. (7)]

3. A CI was submitted to the Ministry of Long-Term Care reporting that resident #003 had a fall, resulting in a transfer to hospital and sustaining an area of altered skin integrity.

Resident #003 was known to staff to lean in their chair and required accommodation with the style of chair.

On the day of the fall the resident was being assisted. The PSW present described the resident as weak and bent forward which caused them to slip off from the chair. The chair make and model was identified. A review of the manufacturer's instructions included safety information to always use the supplied seat belt for safety. The PSW and PRN confirmed the chair did not have a seat belt attached and was not used..

The licensee failed to ensure that resident #003 requiring an identified chair, as part of their plan, of care use the chair in accordance with manufacturers instructions including the use of a seat belt.

Sources: chair manufactures instructions, written plan of care, resident and chair observations, interviews with PSW #111, RPN #110, maintenance worker #112, PT #109 and #113. [s. 6. (7)]

4. A CI was submitted to the Ministry of Long-Term Care reporting resident #002's fall resulting in a transfer to hospital. The resident sustained significant injury and passed away at the hospital.

On the day of admission, the days to evening nursing report documented that the resident required extensive assistance for activities of daily living (ADLs), was at

high risk for falls and incontinent but may still go to the washroom.

i. Progress notes included documentation that the resident's family called the evening of their admission, to remind staff that the resident required a specific falls prevention device to prevent them from getting up from the bed without calling for assistance. The device was not available and the staff used an alternative. The resident was found on the floor between the end of the bed and washroom. Further investigation revealed the falls prevention alternative was non-functioning.

The plan of care for the identified falls prevention device was not provided as planned.

ii. The 24hr care plan stated the resident went to the washroom whenever they needed and staff were to check the resident every two hours for toileting needs when they were in bed, in the evening and night, and provide assistance as needed. An interview with the night PSW revealed that they had not toileted or changed the resident's incontinent brief prior to the residents fall. An interview with RPN #118 who found the resident on the floor stated that they had checked the resident in the night and noticed the resident awake and trying to sit up in bed. The staff did not ask the resident if they would like to use the toilet as the resident had a brief and laid back down and closed their eyes. A little over an hour later the RPN stated they found the resident on the floor between the end of the bed and washroom. The RPN shared they were unaware of the care plan direction and should have asked the resident if they would like to use the toilet and assist them as required when they were awake.

The plan of care to ask the resident if they would like assistance to toilet was not provided as planned.

Sources: 24 hour care plan, Daily Nursing Report sheet, resident health record including progress notes and PT assessments. Interviews with PSW #114, #117, RPN #118 and #119 and the nurse practitioner. [s. 6. (7)]

5. The licensee failed to ensure that when the resident was being reassessed and the plan of care revised, because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

A CI was submitted to the Ministry of Long-Term Care reporting resident #001's

fall resulting in a significant injury and death. The CI stated the resident was found on the floor at near the resident's washroom.

Personal Support Workers interviews identified the resident as independent in mobility, transfers and toileting. Stating the resident would leave the dining room, independently ambulate with their mobility aide back to their room after meals and use the washroom. Staff described the resident as never using the call bell or requesting staff assistance.

Resident #001 had three prior falls which were all linked to the resident not asking for assistance.

The resident's plan of care for safety identified an intervention whereby the resident was encouraged and reminded to call for help either by calling out for staff or using the call bell.

The resident was known to be independent and not ask for help or assistance. The plan of care to encourage the resident to call for help was not effective and other approaches were not considered or implemented leading up to the residents fall resulting in their death.

Sources: Interviews with PSW #100, #101, #102, #103, #107, #108, RN #104. Written plan of care and health record including progress notes and Post Fall Assessments for four falls. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002 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# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program are readily available at the home.

Resident #002 was admitted during the afternoon of an identified day. The resident's family had called that evening to remind staff the resident required a falls prevention device at night. The RPN did not have an available device. The resident fell that evening was transferred to hospital and subsequently passed away.

An interview with the Nurse Practitioner (NP) and Lead for Falls prevention in the home, identified the need to ensure fall prevention supplies, fall mats and bed alarms are readily available to staff on the units. The NP confirmed resident #002 falls brought awareness of the need to ensure supplies and devices are available to staff.

Sources: 24 hour care plan, Daily Nursing Report sheet, resident health record including progress notes and PT assessments. Interviews with PSW #114, #117, RPN #118 and #119 and the nurse practitioner. [s. 49. (3)]

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 equipment, supplies, devices and assistive aids for the falls prevention and management program are readily available at the home, to be implemented voluntarily.

Issued on this 31st day of January, 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 DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2021_595110_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013183-21, 017794-21, 018612-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 31, 2022(A1)
Licensee / Titulaire de permis :	Tendercare Nursing Homes Limited 20 High Park Blvd., Toronto, ON, M6R-1M7
LTC Home / Foyer de SLD :	Tendercare Living Centre 1020 McNicoll Avenue, Scarborough, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roxanne Adams

To Tendercare Nursing Homes Limited, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must comply with s. 8(1) of O. Reg. 79/10.

Specifically, the licensee must ensure that when a resident falls the 'Fall Prevention and Management Policy' including the Post Fall Clinical Pathway is followed by the registered nurse to notify the physician after a fall with injury and assess the resident for the identified medication use.

Grounds / Motifs :

1. The licensee has failed to ensure that that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 70/10, s. 48(1)1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The Homes' 'Fall Prevention and Management Policy' including the Post Fall Clinical Pathway directs the registered nurse to notify the physician after a fall with injury and assess the resident for anticoagulant use.

Resident #001 had an unwitnessed fall and when assessed had sustained an injury.

The resident's medications included a medication that interfered with blood clotting. The resident was given this medication on the day of the fall.

An interview with the responding RN stated they were unaware the resident was taking the identified medication at the time of the fall and confirmed that they should have notified the physician of the resident's fall and injury.

The resident was transferred to hospital, diagnosed with a condition complicated by the lack of blood clotting and passed away.

Sources: final discharge summary, medication administration records, post fall assessment, progress notes, written care plan. Staff interviews with RN #104, PSW #108 and DOC #105. [s. 8. (1)]

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

Severity: There was actual risk of harm to the residents, as the failure to follow the homes' 'Fall Prevention and Management Policy' including the Post Fall Clinical Pathway and may have resulted in a delay in the resident seeking immediate medical attention.
Scope: This non-compliance was isolated as one out of three residents were noted not to have been assessed according to the homes policy.
Compliance History: one non-compliance was issued to the home related to same sub-sections of the legislation in the past 36 months.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2022(A1)

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: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 6 (7) of the Long-Term Care Homes Act, S.O.
2007, c. 8.

Specifically, the licensee must ensure that the care set out in the plan of care for
the purpose of falls prevention is provided to the resident as specified in the plan.

Grounds / Motifs :

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

1. The licensee failed to ensure the care set out in the plan of care provided to the resident as specified in the plan.

A CI was submitted to the Ministry of Long-Term Care reporting resident #001’s fall resulting in a significant change of status and subsequent death.

On the night of the resident's fall PSW #107 stated the resident independently left the dining room with their mobility aide and RN #104 found the resident on the floor, in their room, while administering medications in the area. The resident was on the floor by the resident’s washroom, presumedly, according to the RN, waiting to use the washroom as it was occupied.

The resident’s plan of care identified one staff assistance for mobility, transfers and toileting assistance for safety. The licensee failed to ensure the care set out in the plan of care provided to the resident as specified in the plan.

Sources: Interviews with PSW #100, #101, #102, #103, #107, #108, RN #104. Written plan of care and health record including progress notes and Post Fall Assessments for four falls. [s. 6. (7)]

(110)

2. A CI was submitted to the Ministry of Long-Term Care reporting that resident #003 had a fall, resulting in a transfer to hospital and sustaining an area of altered skin integrity.

Resident #003 was known to staff to lean in their chair and required accommodation with the style of chair.

On the day of the fall the resident was being assisted. The PSW present described the resident as weak and bent forward which caused them to slip off from the chair. The chair make and model was identified. A review of the manufacturer's instructions included safety information to always use the supplied seat belt for safety. The PSW and PRN confirmed the chair did not have a seat belt attached and was not used..

The licensee failed to ensure that resident #003 requiring an identified chair, as part of their plan, of care use the chair in accordance with manufacturers instructions including the use of a seat belt.

Sources: chair manufactures instructions, written plan of care, resident and chair observations, interviews with PSW #111, RPN #110, maintenance worker #112, PT #109 and #113. [s. 6. (7)]

(110)

3. A CI was submitted to the Ministry of Long-Term Care reporting resident #002's fall resulting in a transfer to hospital. The resident sustained significant injury and passed away at the hospital.

On the day of admission, the days to evening nursing report documented that the resident required extensive assistance for activities of daily living (ADLs), was at high risk for falls and incontinent but may still go to the washroom.

i. Progress notes included documentation that the resident's family called the evening of their admission, to remind staff that the resident required a specific falls prevention device to prevent them from getting up from the bed without calling for assistance. The device was not available and the staff used an alternative. The resident was found on the floor between the end of the bed and washroom. Further

investigation revealed the falls prevention alternative was non- functioning.

The plan of care for the identified falls prevention device was not provided as planned.

ii. The 24hr care plan stated the resident went to the washroom whenever they needed and staff were to check the resident every two hours for toileting needs when they were in bed, in the evening and night, and provide assistance as needed. An interview with the night PSW revealed that they had not toileted or changed the resident's incontinent brief prior to the residents fall. An interview with RPN #118 who found the resident on the floor stated that they had checked the resident in the night and noticed the resident awake and trying to sit up in bed. The staff did not ask the resident if they would like to use the toilet as the resident had a brief and laid back down and closed their eyes. A little over an hour later the RPN stated they found the resident on the floor between the end of the bed and washroom. The RPN shared they were unaware of the care plan direction and should have asked the resident if they would like to use the toilet and assist them as required when they were awake.

The plan of care to ask the resident if they would like assistance to toilet was not provided as planned.

Sources: 24 hour care plan, Daily Nursing Report sheet, resident health record including progress notes and PT assessments. Interviews with PSW #114, #117, RPN #118 and #119 and the nurse practitioner. [s. 6. (7)]

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

Severity: There was actual harm to the resident #001, #002 and #003, as the failure to provide care for falls prevention in accordance with the resident's plan of care
Scope: This non-compliance was widespread as three out of three residents were impacted.
Compliance History: Three non-compliances were issued in last 36 months to the home related to the same sub-sections of the legislation.
(110)

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 : Mar 02, 2022(A1)

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 31st day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by DIANE BROWN (110) - (A1)

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

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