Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**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**

Central West Service Area Office
500 Weber Street North
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## Public Copy/Copie 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 |
|---|---|---|---|
| Nov 9, 2018 | 2018_739694_0015 | 025407-18 | Resident Quality Inspection |

### 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 Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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

AMANDA COULTER (694), JANET GROUX (606), KATHLEEN MILLAR (527)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): September 17, 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2018.**

**The following Critical Incident System (CIS) were inspected concurrently with the Resident Quality Inspection (RQI):**
**CIS:**
**Log #009851-18 and Log #018464-18 related to Fall Prevention**
**Log #017569-18 and Log #013864-18 related to Prevention of Abuse and Neglect**

**Follow Up:**
**Log #021327-18 , Compliance Order (CO) #001 related to review and revision of Plan of Care and**
**Log #021328-18 CO #002 related to Responsive Behaviours**

**The following on-site inquiries were completed concurrently with the RQI:**
**Log #005031-18, Log #009492-18, and Log #019646-18 related to a fall**
**Log #008758-18 related to Responsive Behaviours**
**Log #009591-18 related to maintenance services**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Program Manager, Social Service Worker (SSW), Physiotherapist, Food Service Supervisor (FSS), Maintenance Supervisor, the Resident Council President, the Family Council President, Family members and residents.**

**During the course of the inspection, the inspectors toured the facility, reviewed resident clinical records, reviewed facility's policies and education attendance.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 53. (4) | CO #002 | 2018_737640_0013 | 527 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (10) | CO #001 | 2018_737640_0013 | 527 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: 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. (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).**

**Findings/Faits saillants :**

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

Resident #006 had a fall while attempting to self-transfer on a specific date in May 2018, which resulted in the resident sustaining an injury.

The clinical record was reviewed and the plan of care for falls prevention indicated the resident required two staff to assist the resident to the washroom and that one staff to remain with the resident at all times, as the resident was high risk for falls and the resident would attempt to self-transfer.

PSW #106 was interviewed and acknowledged the resident was a two person transfer for toileting, was on a toileting schedule to prevent them from attempting to go to the bathroom on their own, and a PSW should always stay with the resident. The PSW said the resident was high risk for falls and should not be left alone on the toilet.

RPN #119 was interviewed and confirmed that the resident was a two person transfer for toileting, one PSW must stay with the resident in the bathroom because the resident would try to self-transfer and could fall.

The licensee failed to ensure that the care set out in the plan of care for resident #006, was provided to the resident as specified in the plan. (527) [s. 6. (7)]

***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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

During the Resident Quality Inspection (RQI), resident #002 was identified as being incontinent according to the most recent minimum data set (MDS).

The inspector observed on a specific date in September 2018, PSW #113 entered resident #002's room and informed the resident that they were going to toilet the resident.

Interview with PSW #113 revealed that resident #002 is at times capable of going to the bathroom with only one staff assisting them. They confirmed that they transferred resident #002 by themselves.

Review of resident #002's written care plan identified the resident to have impaired mobility and required extensive assistance of two staff for transfer to the toilet using a device for transfers on and off the toilet.

Interview with RPN #119 stated that resident #002's care plan stated that the resident was required to be toileted by two staff. The RPN acknowledged that PSW #113 did not use safe transferring technique for resident #002.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002 and #006. [s. 36.]

***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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted:  have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential.

During a meal service observation on a specific date in September 2018, the Long Term Care Homes (LTCH) inspector observed in all the home's dining areas, the seating plan posted included the diet textures of the residents' on the unit.

The home's policy entitled, "Seating Plans", NC-03-01-10, last revised December 2017, indicated that only the residents names will be documented on the seating plan.

Interviews with RPN #114, RN #115 and Food Service Manager #116 stated that the residents' diets should not have been included in the seating plan as this was considered personal health information.

The licensee failed to ensure that the following rights of residents were fully respected and promoted:  have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential. [s. 3. (1) 11. iv.]

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**WN #4:  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. In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including Falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out

in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

A) On a specific date in July 2018, resident #001 had a fall resulting in an injury and was transferred to the hospital for further assessment and diagnosed with a specific injury.

The licensee's policy titled "Falls Prevention and Management Program", number RC-15-01-01, and last revised on February 2017, directed staff to flag residents at high risk for falls or fall injuries using the Falling Leaf logo.

The clinical record was reviewed, which identified on the falls risk assessment and the plan of care that the resident was high risk for falls.

The resident was observed on a specific dates in September 2018. During each observation there was no flag that the resident was at high risk for falls.

RPN #104 was interviewed and said that the resident was high risk and had frequently fallen since admission. RPN #104 acknowledged the resident should not have had the high risk logo on their mobility assistive device. PSW #126 was interviewed and acknowledged the falling leaf logo was used to alert all staff when a resident was high risk for falls. The PSW was not aware that resident #001 was high risk for falls.

B) On a specific date in May 2018, resident #006 had an unwitnessed fall and sustained an injury and was transferred to the hospital for further assessment.

The licensee's policy titled "Falls Prevention and Management Program", number RC-15-01-01, and last revised in February 2017, directed staff to monitor the following every hour for four hours, then every eight hours for 72 hrs:

- Neurovital Signs (if head/brain injury suspected or the fall is unwitnessed);
- Monitor vital signs;
- Assess for pain; and
- Monitor for changes in behaviour.

The clinical record was reviewed and there was no clinical monitoring of the resident every hour (hr) and/or every eight hrs after the fall. The resident had their initial post fall assessment immediately after the fall and there was no further clinical monitoring until

hours later.

RPN #119 was interviewed and said that they were expected to complete the clinical monitoring, which included neurological vital signs every hr for four hrs and then every eight hours for 72 hrs, especially if the resident hit their head and/or the fall was unwitnessed.

The DOC was interviewed and also acknowledged that staff were expected to complete the clinical monitoring as outlined in their policy and procedures.

The licensee failed to ensure that the Falls Prevention and Management Program policy and procedures were complied for resident # 001 and #006. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #5: 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 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.

A) Resident #008 was admitted to the home on a specific date in April 2017.

A Critical Incident Systems (CIS) report was submitted to the Director on a specific date in July 2018 stated that there was an incident of alleged abuse that occurred on a specific date in July 2018 by staff member #109 towards resident #008.

In an interview with staff #121 they acknowledged resident #008 reported to them they

felt a staff member, was speaking to them disrespectfully, calling the resident names and neglected to help resident #008 when they requested assistance. Staff member #121 listened to the resident's concerns but did not report them to management until the next day.

According to the Administrator's notes and the home's investigation, notification to the Substitute Decision Maker (SDM) of resident #008 did not occur immediately.

The home's policy titled "Zero tolerance of Resident Abuse and Neglect: Response and Reporting", number RC-02-01-01, last revised April 2017 directed all staff to immediately respond to any form of alleged, potential or witnessed abuse. The person reporting the suspected abuse will follow the home's reporting/provincial requirements to ensure the information is provided to the home Administrator/designate immediately and an investigation would be initiated immediately. The home's procedure included disclosure of alleged abuse be made to the resident Substitute Decision Maker (SDM), immediately upon becoming aware of the incident, unless the SDM is the alleged perpetrator.

B) Resident #009 was admitted to the home on a specific date in March 2017.

A CIS report was submitted to the Director on a specific date in June 2018 stated there was an incident of alleged abuse by staff #131 towards resident #009 that was documented in the resident's clinical record.

A clinical record review was completed and indicated documentation completed by staff #132 the resident reported that staff #131 assaulted them. When assessed by staff #132, resident #009 had an altered skin integrity and complained of pain when the area was touched.

In an interview with staff #131, the Registered Nurse (RN) acknowledged they notified staff coming on duty. Staff #131 returned to work on a different date in June 2018, and the Administrator/designate, the physician were not notified immediately. In an interview with Staff #132, they acknowledged that these incidents met their home's definition of abuse and were unsure if management was notified immediately of the incident. The home's investigation was not initiated until a number of days after the incident on a specific date in July 2018.

The licensee has failed to ensure that 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. [s. 20. (1)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must 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. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee's 2017 Fall Prevention Evaluation was reviewed. There were no dates related to the changes implemented from the summary of changes. The written record identified a list of objectives; however there were no measureable outcomes and/or actions identified and the dates for implementation.

The DOC was interviewed and acknowledged that they had not identified any dates of when their changes were to be implemented from their summary of changes in the 2017 Fall Prevention Evaluation.

The licensee failed to ensure that the written record included a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 3.]

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**Specifically failed to comply with the following:**

**s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During a tour on a specific date in September 2018, the inspector #606 observed that the home's Ministry of Health and Long Term Care (MOHLTC) Inspection Report were not in an easily accessible location. Further observations noted that there were no written information posted on how a person can obtain any previous reports for the past two years.

Interview with the Administrator stated that only the most current MOHLTC inspection report was posted as any previous reports would be available on request. They acknowledged that the inspection reports were not easily accessible for anyone to obtain. [s. 79. (1)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

**Specifically failed to comply with the following:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that (iv) there was a process to report and locate residents' lost clothing and personal items.

During the home's RQI, an interview with resident #002's SDM revealed that they had reported on a specific date in August 2018, that resident's personal item was missing and reported their concern to the Charge Nurse. They stated that the home did not get back to them on the status of their concern and told the inspector that the resident's personal item was still missing.

Interview with PSW #106 stated that the home's practice was when there is a concern regarding a resident missing a personal item, the concern should be reported to the Charge Nurse and acknowledge that they did not report it.

Interview with RPN #119 stated that they were not informed that resident #002's personal item had been missing.

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, the home's procedure of reporting a concern regarding a resident missing personal item was not implemented. [s. 89. (1) (a) (iv)]

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**Issued on this 14th day of November, 2018**

**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**

**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

**Ministère de la Santé et des Soins de longue durée**

**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**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | AMANDA COULTER (694), JANET GROUX (606), KATHLEEN MILLAR (527) |
| **Inspection No. / No de l'inspection :** | 2018_739694_0015 |
| **Log No. / No de registre :** | 025407-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 9, 2018 |
| **Licensee / Titulaire de permis :** | Extendicare (Canada) Inc.<br>3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9 |
| **LTC Home / Foyer de SLD :** | Extendicare Brampton<br>7891 McLaughlin Road, BRAMPTON, ON, L6Y-5H8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Hannah Oksemberg |

Ontario

**Ministry of Health and Long-Term Care**

**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

**Ministère de la Santé et des Soins de longue durée**

**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 # / 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. 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 be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically the licensee must:

a) Ensure that care set out in the plan of care for resident #006 and any other resident, are provided to the resident as specified in the plan.

**Grounds / Motifs :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

During the Resident Quality Inspection (RQI), resident #002 was identified as being incontinent according to the most recent minimum data set (MDS).

The inspector observed on a specific date in September 2018, PSW #113 entered resident #002's room and informed the resident that they were going to toilet the resident.

Interview with PSW #113 revealed that resident #002 is at times capable of going to the bathroom with only one staff assisting them. They confirmed that they transferred resident #002 by themselves.

Review of resident #002's written care plan identified the resident to have impaired mobility and required extensive assistance of two staff for transfer to the toilet using a device for transfers on and off the toilet.

Interview with RPN #119 stated that resident #002's care plan stated that the resident was required to be toileted by two staff. The RPN acknowledged that PSW #113 did not use safe transferring technique for resident #002.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002 and #006.

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.6 (7) of LTCHA 2007. The factors include scope, severity and history of non-compliance. The scope of the non-compliance was a level 1, the severity of the non-compliance was actual harm to one resident and the history of non-compliance is one or more unrelated non compliance in last 36 months.
(694)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2018

Ontario

**Ministry of Health and Long-Term Care**

## 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

**Ministère de la Santé et des Soins de longue durée**

## 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 9th day of November, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amanda Coulter

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office