Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
Aug 03, 2021	2021_583117_0014 (A1)	003225-21, 003226-21	Follow up

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street Ottawa ON K1S 5G6

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

Glebe Centre
77 Monk Street Ottawa ON K1S 5A7

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's administrator requested an extension to the compliance due date of September 30 2021 for both Compliance Orders CO #001 and CO#002. The new requested compliance due date is November 30 2021. This was approved.

Issued on this 3 rd day of August, 2021 (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

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, and 23, 2021

During the inspection, the following inspection logs were completed:

- Log # 003225-21: Compliance Order CO #001 issued on February 18, 2021 under inspection report #2021_617148_0005 related to O.Reg. 79/10 s. 15 (1) Bed Rails with a compliance due date of May 18, 2021.

- Log # 003226-21: Compliance Order CO #002 issued on February 18, 2021 under inspection report #2021_617148_0005 related to O.Reg. 79/10 s. 26(3) Plan of Care with a compliance due date of May 18, 2021.

It is noted that Inspector Gurpreet Gill #705004 participated in the inspection as an observer.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quatliy Management, the Director of Care (DOC), Manager of Nursing Care, PSW Supervisor, Infection Control Lead, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), a Physiotherapist, a Volunteer Coordinator, Environmental Services Manager (ESM), housekeeping staff, maintenance staff, several Dietary Aides (DA), COVID screeners, Regional IPAC Team, several essential caregivers and to several residents.

During the course of the inspection, the inspectors reviewed several resident health care records, observed the provision of resident care and services, observed infection control practices and reviewed the infection control program, observed the provision of beverage and snack collation, observed the several lunch time meal services, observed resident room and common areas, reviewed the monitoring and documentation of air temperatures, observed medication administration and reviewed policy # MM4.02.00 – Medication Administration Process, last revised October 2019 , reviewed the bed rail assessment / bed entrapment program and associated documents.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Safe and Secure Home

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

- **8 WN(s)**
- **5 VPC(s)**
- **2 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. 26. (3)	CO #002	2021_617148_0005	117

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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to comply with Compliance Order CO #001 issued on February 18, 2021 under inspection report #2021_617148_0005 related to O.Reg. 79/10 s. 15 (1) Bed Rails with a compliance due date of May 18, 2021.

A review of the home's compliance order plan and actions taken was conducted with the home's DOC and an RN, ESM, physiotherapist and the Director of Quality Management.

The following was noted:
The licensee reviewed the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003), "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (FDA, 2006)" and the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Education on these documents was provided to registered nursing staff

The RN and other registered nurses identified 70 residents out of 213 in the home that used bed rails. The plans of care for residents who were not able to use bed rails, were revised to identify that bed rails were not to be used. It is also noted that residents who did not use bed rails were not assessed as part of this process and that bed rails are still present on resident bed systems, even when not in use.

The RN and the DOC reported that they developed a "Bed Entrapment Risk Assessment Tool". Training on its use was provided to registered nursing staff. However, the tool's use had not been fully implemented at the time of the inspection. As per the DOC and the RN only a few residents had been assessed with the "Bed Entrapment Risk Assessment Tool" at the time of the inspection.

The ESM and the RN reported that the home purchased a "Bed Entrapment Testing Tool". Training on its use was provided to some registered nursing staff. However, the tool's use had not been fully implemented at the time of the inspection. As per the ESM, only a few resident bed systems had been assessed with the "Bed Entrapment Testing Tool". During further discussion, it was identified that other safety issues related to the use of bed rails were not addressed, including height and latch reliability, as part of their evaluation process.

As such, the home did not meet the ordered requirements as identified in

Compliance Order CO #001 issued on February 18, 2021 under inspection report #2021_617148_0005. The ordered requirements were as follows:
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Sources: observations of resident bed systems, review of residents plan of care, Bed Entrapment Risk Assessment Tool, Bed Entrapment Testing Tool use, Interviews with DOC, RN, ESM and physiotherapist [s. 15. (1) (a)]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

It is noted that the home was in a suspected COVID outbreak from June 11 to June 22, 2021.

On June 09, 2021, an inspector observed a resident in room. There was an infection control sign for contact precautions at the room door. It was noted that there were no gloves at the room entrance and in the room as part of the available Personal Protective Equipment (PPE) supplies.

On June 14, 2021, a PSW was observed to pass the morning beverage pass in unit's TV Lounge area. The PSW prepared and provided fluid beverage assistance to three (3) residents without performing hand hygiene. The PSW said to the inspector that staff only need to perform hand hygiene before and after beverage passes if they had touched the resident during beverage assistance or had assisted with resident hand and face washing. It was noted that there was a bottle of alcohol-based hand rub (ABHR) on the beverage cart at the time of the beverage pass which was accessible for staff use.

On June 14, 2021, an essential caregiver was observed providing feeding assistance to a resident in their room. The resident was identified to be in isolation as per a PSW and requiring that full Personal Protective Equipment (PPE) be worn during the provision of care. However, no infection control signage was noted to be at resident room entrance.

June 14, 2021, a staff member was observed to not be wearing gloves while providing feeding assistance to a resident. All residents of the unit were under contact and droplet precautions. Staff were to wear full PPE when providing direct care. The staff member said that they were not aware of need to wear gloves as part of contact and droplet precautions when providing feeding assistance. The staff member then proceeded to do hand hygiene and put on gloves for the rest of the resident's provision of care.

On June 14, 2021, a PSW was observed to pass the afternoon snack beverage pass. The PSW prepared and provided snacks and beverages to two residents as well as provided feeding assistance to another resident in the activity lounge without performing hand hygiene. The PSW said to the inspector that they had

forgotten to do hand hygiene during the snack pass. It was noted that there was a bottle of ABHR on the snack cart as well as in the activity lounge.

On June 14, 2021, a PSW was observed to pass the afternoon snack beverage pass. The PSW prepared and provided snacks and beverages to four (4) residents as well as provided feeding assistance to a resident in their room without performing hand hygiene. The PSW was also observed to enter room of a resident that was under isolation precautions without performing hand hygiene prior to donning PPE to enter the room and did not follow correct doffing and hand hygiene procedures after exiting the room. The PSW said to the inspector that they had forgotten to do hand hygiene during the snack pass. It was noted that there was a bottle of ABHR on the snack cart as well as at several locations on the unit hallways.

Discussion held with a unit RPN regarding isolation precautions for a resident. PPE supplies were at the room door entrance but there was no infection control sign. The RPN reported that the identified resident was under droplet and contact precautions, that nursing staff were aware of this. The RPN was not aware that there was no infection control sign at the resident room entrance.

On June 15, 2021, two PSWs were observed by an inspector to be providing feeding assistance to two identified residents respectively. When finished, the PSWs then went to provide feeding assistance to two other residents without doing hand hygiene. It was noted that ABHR was available at several locations in the dining room. Three residents arrived in the unit dining room, sat at their assigned tables and were served their lunch time meal. No hand hygiene was observed to be done by the residents prior to the start of their meal. PSW staff present in the dining room, did not provide hand hygiene assistance for these three residents.

On June 15, 2021, an RPN was observed to do the lunch time medication administration pass. The inspector observed the RPN administer medications to five (5) residents without doing hand hygiene prior to preparing and after administering the medications. It was noted that for all five (5) residents, the administered medication had to be crushed, mixed in apple sauce and administered with the aid of a spoon by the RPN. The RPN reported to an inspector that they forgot to do hand hygiene during the medication pass.

On June 16, 2021 signage for Contact Precautions and door hanging isolation

station with gowns and gloves were observed by an inspector outside of an identified resident's room. The signage and PPE were not present on previous tours of the unit on June 8 and 15, 2021. A review of the resident's health care record noted the presence of an infection. The RPN stated that the resident was on contact precautions for care.

Discussion was held on June 14, 2021 with the home's Infection Control Lead. They reported to the inspector that staff are to follow the home's infection control program. The program identifies that any resident who is placed in isolation, needs to have an infection control sign at their room entrance to clearly identify to staff what type of PPE they are to use when providing care to the resident. Staff also need to ensure that PPE supplies are readily available at resident room entrance to facilitate resident provision of care. The Infection Control Lead said that they would follow up with nursing staff to ensure that the correct infection control signs were in place for two identified residents and correct supplies for an identified resident room.

Discussion was held on June 15, 2021 with the home's DOC, Manager of Nursing Care, PSW Supervisor and the home's Infection Control Lead regarding he home's infection control program. The nursing management team acknowledged that staff are not consistently following the home's infection control program such as hand hygiene and correct wearing of PPE. Audits and staff re-education are being done when staff are observed to not be following infection control directives. They have also reached out to the Regional IPAC Team for educational support in May 2021.

As such, staff were not following the home's infection control program, posing infection control risks to residents when the home was in a suspected COVID outbreak.

Sources: Residents health care record, Observations made by inspectors, Interviews with several PSW staff, three RPNs, DOC, Manager of Nursing Care, PSW Supervisor and the home's Infection Control Lead. [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

As per Directive #3 for Long-Term Care Homes, under the Long-Term Care Homes Act, 2007, all individuals must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the LTCH and for outdoor visits.

On June 21, 2021 at approximately 16:45, an inspector observed a visitor approached the screening desk between a set of double doors. The screener did not ask the visitor any screening questions for symptoms or exposure history before granting them entry to the home.

Sources: Directive #3 (May 21, 2021) and observations made by inspector. [s. 5.]

2. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

As per Directive #3 for Long-Term Care Homes, under the Long-Term Care Homes Act, 2007, staff are required to comply with universal masking at all times,

even when they are not delivering direct patient care, including in administrative areas. Masks must not be removed when staff are in contact with residents and/or in designated resident areas.

All staff and essential visitors are required to wear appropriate eye protection (e.g., goggles or face shield) when they are within two (2) metres of a resident(s) as part of provision of direct care and/or when they interact with a resident(s) in an indoor area.

It is noted that the home was deemed to be in a suspected COVID outbreak from June 11 to June 22, 2021.

On June 15, 2021, the following observations were made on a resident care unit by an inspector:

From 1231-1236 hours, a Dietary Aide was observed in the dining room without a face mask and eye protection. Four residents and one PSW were present in the dining room.

From 1231-1259 hours, a PSW was observed in the hallway and dining room with their face mask under their chin. On June 16, 2021, between 1139 and 1219 hours the same PSW was observed several times in the dining room with their face mask not covering their nose, and their nares exposed.

A housekeeper was in an identified resident room with their mask pulled down below their mouth and eye protection removed. The housekeeper was observed in the hallway within 2 meters of another housekeeping staff member, and neither staff member were wearing eye protection. During the lunch meal, the same housekeeper was observed walking through the dining room three times, within 2 meters of residents, with no eye protection.

One staff member, who was not wearing eye protection, delivered laundry to a resident’s room and came within 2 meters of residents. A second staff member, who was not wearing eye protection, delivered laundry to the nursing station and came within 2 meters of a resident.

On June 14, 2021 at 1100 hours, a management staff member was providing administrative assistance for the home’s COVID surveillance staff.The management staff member was wearing a mask but was not wearing eye

protection in the testing area. They indicated to the inspectors that the home did not have additional re-usable face shields for them to wear at that time. Soon after, a maintenance staff brought disposable face shields to the testing area and the staff member then put on a disposable face shield.

On June 14, 2021, on another unit, at 1135 hours, two PSWs were observed to be providing feeding assistance to two residents. Both were wearing masks, but their eye protection face shields were positioned on their foreheads. When asked why their eye protection was not worn correctly, both said that they were hot and had lifted their face shields to alleviate the heat.

On June 14, 2021, at 1150 hours, an essential caregiver was observed to providing feeding assistance to a resident in their room.The resident was identified to be in isolation and requiring that full Personal Protective Equipment (PPE) be worn during the provision of care. The essential caregiver was wearing mask but did not have eye protection or any other PPE.

On June 15, 2021, on another unit, at 1200 hours, a PSW was observed by an inspector to be providing feeding assistance to a resident. The PSW's face shield was positioned up on the forehead. When finished, the PSW then went to assist another resident. The PSW's face shield was still up on their forehead when they started to provide feeding assistance to another resident. When asked by the inspector as to why their eye protection was not correctly in place, the PSW said that they were hot and had pushed their face shield up. The PSW acknowledged that they were aware that eye protection was to be worn when providing resident care. They then positioned the face shield correctly in place.

On June 16, 2021 at 1050 hours, the inspectors observed a management staff member speaking to a resident. The resident was seated in a chair in the lounge area outside of the home's administrative offices. The resident wore a mask as did the management staff member when the staff was observed to pull their mask down to speak to the resident, less than 2 meters from the resident.

On June 16, 2021, on a resident care unit at 1202 hours, an inspector observed a Dietary Aide (DA) serving the lunch time meal at the unit servery, interacting with several residents and PSWs. They wore a mask, but their face shield was up on the forehead and not correctly positioned.

On June 16, 2021, at 1210 on a resident care unit, an inspector observed a PSW

feeding a resident. The PSW was wearing a mask and their face shield was positioned on top of their forehead while providing feeding assistance. When the inspector approached, the PSW repositioned their face shield correctly. When ask about the correct wearing of eye protection, the PSW said that they had forgotten to pull their face shield down when providing resident assistance.

Discussion was held on June 15, 2021 with the home's DOC, Manager of Nursing Care, PSW Supervisor and the home's Infection Control Lead regarding Directive #3 and the home's infection control program. The nursing management team acknowledged that staff are not consistently following infection control directives even after audits and re-education is completed when staff are observed to not be following infection control directives.

As such, staff were not following Directive #3 in regard to the proper wearing of masks and face shields when less than 2 meters from residents, posing infection control risks to residents when the home was in a suspected COVID outbreak.

Sources: Directive #3 (May 21, 2021), observations made by the inspectors, Interviews with several PSWs, DOC, Manager of Nursing Care, PSW Supervision and the home's Infection Control Lead. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

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. The licensee has failed to ensure that the policy regarding medication administration is complied with.

As per O.Reg. s. 114, the licensee is to have a Medication Management System and that licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy # MM4.02.00 – Medication Administration Process, last revised October 2019, under "Procedure", identifies the following: "Medications shall be prepared, administered and signed off for one resident before preparing and/or administered medications for the next resident." It also identifies that the resident medication are to be verified with the electronic Medication Administration Record (eMAR) prior to the preparation, administer the medication as per the order, return to the medication cart and document the medication administration.

On June 15, 2021, an RPN was observed to do the lunch time medication administration pass. The inspector observed the RPN administer medications to five (5) residents without verifying the medication to be administered and did not document the administered medication immediately after these were administered the residents.

A review the eMARs for four (4) of the identified residents documents that administered medications were signed 20 minutes after these were observed to be given to the residents. The eMAR for the fifth resident documents that the medications were signed as being given 10 minutes prior to the medication

observed to being given to the resident.

A review of the home's medication administration policy # MM4.02.00 – Medication Administration Process, last revised October 2019 identifies that resident medications shall be prepared, administered and signed off for one resident before preparing and/or administering medications for the next resident. It also identifies that the eMAR medication is to be verified as per order prior to the preparation and administration of the medication and that following the medication administration this is to be documented.

The RPN indicated to the inspector that they documented the administered medications after they were given via the computer that is in the nursing station and not the system on the medication cart. The RPN also acknowledged that they did not verify resident medication orders prior to their administration. The home's DOC confirmed to the inspector that home's policy and practice is to verify resident medication orders prior to preparation and administration and to document the administered medication after these have been given to the resident.

As such, by not following the medication administration policy there is the potential risk of a medication error as the medications were not verified prior to preparation and administration during the medication pass, nor were their administration documented immediately after administration.

Sources: Interviews RPN and DOC, Observations of medication pass for five residents, eMAR documentation for five residents, home's policy # MM4.02.00 – Medication Administration Process, last revised October 2019. [s. 8. (1) (b)]

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 the policy regarding medication administration is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature measured and documented in writing in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor and at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night

On June 8, 9, 10, 2021, a review of the home's air temperature monitoring system was done. The ESM informed the inspector that the home monitors and documents the HVAC units air temperature at the point of system exit, located on the roof of the home, and at ceiling diffusers point of delivery, via a centralized computer system. The ESM said that the home has not been taking and documenting the air temperatures in:
- two resident bedrooms, in different parts of the home,
- in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor
- at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night

The ESM and Administrator said that they were looking at various technologies to facilitate the implementation of the legislated requirements but had not taken steps to ensure that air temperatures were monitored and documented in the meantime. The home started to monitor and document air temperatures as of June 10, 2021. As such, there was a potential risk to residents of being impacted by elevated temperatures within the home as air temperatures were not monitored and documented as per legislated requirements between May 15 and June 10, 2021.

Sources: Interviews ESM and Administrator, temperature documentation. [s. 21. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperature measured and documented in writing in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor and at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #6: 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 :

1. The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.

On June 23, 2021 at 1350 hours the inspectors entered an identified resident's room and found the resident to be seated in the sit to stand lift, on a commode, situated on top of the toilet. No staff were in attendance. The resident was not holding on to the sit to stand lift, was leaning backwards and sideways, and was drowsy.

Inspectors called for assistance. An RPN and two PSWs arrived and assisted the resident off of the toilet and transferred the resident to bed. The resident was not injured.

An identified PSW reported that they had transferred the resident with the assistance of another PSW on the toilet with the sit to stand lift. the second PSW had left the room to provide care to another resident. The identified PSW said that they had left the resident unsupervised and alone in the transfer lift, on the toilet. They did not call for another staff member to come and stay with the resident when they had left the room. The identified PSW, DOC and PSW Supervisor acknowledged that residents are not be left unattended and unsupervised when in a mechanical lift. By not executing a safe transferring techniques and leaving the resident unattended in a sit to stand lift, this posed a potential risk of injury to the resident.

Sources: Observation of a resident , Staff interviews with two PSWs, DOC and PSW Supervisor. [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 techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was offered three meals daily.

On June 15, 2021, a resident was observed throughout the entire lunch meal.

The resident was served one glass of cranberry juice. At 1247 hours, an identified PSW asked the resident if they wanted to go to their room. The inspector asked the PSW if the resident had been offered lunch. The PSW asked the registered staff member who replied "I think so". The resident was escorted from the dining room without being offered a lunch meal.

A review of the resident's health care record indicated that the resident is malnourished and was to be offered a diet with high calorie and protein interventions.

Sources: Resident health care record and observations of the inspector. [s. 71. (3) (a)]

2. The licensee has failed to ensure that the planned dessert items were offered to a resident at a lunch meal.

On June 15, 2021,an identified resident came to the dining room and was served their entrée at 1210 hours.
At 1241 hours when the Dietary Aide went to clear the resident's plate, the resident stated that they had not received dessert. The Dietary Aide replied, "You had dessert, you had your lunch". An identified PSW asked the Dietary Aide to offer the resident coffee which they accepted. No dessert was offered.

A review of the resident's health care record indicated that the resident had variable intakes at meals and required high calorie and protein interventions. There was no indication that the resident was not to be offered dessert.

Sources: Resident health care record and observations of the inspector. . [s. 71. (4)]

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 residents are offered three meals daily and to ensure that the planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee failed to comply with the required actions in regards to an identified resident for compliance order #002 issued on February 18, 2021.

A compliance order CO #002 was issued on February 18, 2021 under inspection report #2021_617148_0005 related to O.Reg. 79/10 s. 26 (3) Plan of care with a compliance due date of May 18, 2021. There were two parts to the order: Part 1) to ensure that the plan of care for two identified residents are reviewed and revised to include the type and level of assistance that is required related to activities of daily living (ADL) and part 2) that the plans of care must include the type and level of assistance for bed mobility, toileting and hygiene.

A review of the Compliance Order #002 was conducted from June 8 to June 23, 2021. The home's Manager of Quality Improvement, Director of Care, Manager of Nursing Care, PSW Supervisor and registered nursing staff, reviewed and revised the plan of care to ensure they include the type and level of assistance for bed mobility, toileting and hygiene for one of the identified residents. It is noted that

this was also completed for all of other residents in the home.

The second identified resident's plan of care identifies that the type and level of assistance for ADLs, bed mobility and hygiene was reviewed and revised. The plan of care for toileting was reviewed but changes to the toileting plan of care were not communicated to nursing staff. The plan of care dated May 2021 identifies that the resident is not toileted, but that continence care is to be provided when the resident is in bed. It also identifies that the resident is transferred via the use of a mechanical lift with a hammock sling and a sit to stand PRN (on an as needed basis).

In the resident’s room, it was observed by the inspectors that there were two transfer logos at the resident’s bedside. One for the use of a mechanical lift and one for the use of a sit to stand lift for toileting.Three (3) PSWs said that they toilet the resident with a sit to stand lift and were not aware that the plan of care had been reviewed and revised to identify that the resident was to be toileted in bed.

On June 22, 2021, the Manager for Nursing Care reviewed the identified resident’s plan of care with the inspectors. The discrepancies between the resident’s written plan of care and the transfer logos at the resident bedside were discussed. The Manager for Nursing confirmed that the plan of care identifies the resident as being cognitively impaired and requires extensive 2-person assistance for all ADLs. Because of this, the resident should not be toileted with the use of a sit to stand lift. The discrepancy between the plan of care and the bedside transfer logos were identified in the home’s audit process but have not been addressed. As such, the identified resident’s toileting care needs as identified in the reviewed and revised plan of care did not include the revision of toileting logos at the resident bedside posing an actual risk to the resident as they are not receiving their toileting care as identified in the plan of care.

Sources: Plan of care and Health Care Record for two identified residents, Review of Home Audit Records for Transfer Logos, Observation of resident room transfer logs, Interview Manager of Nursing Care and and 3 PSWs. [s. 101. (3)]

Issued on this 3 rd day of August, 2021 (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 LYNE DUCHESNE (117) - (A1)
Inspection No. / No de l'inspection :	2021_583117_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003225-21, 003226-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 03, 2021(A1)
Licensee / Titulaire de permis :	The Glebe Centre Incorporated 950 Bank Street, Ottawa, ON, K1S-5G6
LTC Home / Foyer de SLD :	Glebe Centre 77 Monk Street, Ottawa, ON, K1S-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lawrence Grant

To The Glebe Centre Incorporated, 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 # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_617148_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 15 (1)
Specifically, the licensee shall:
1) Ensure that bed rail use, for resident # 002, #003 and all other residents in the home, are assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral
symptoms; sleep habits; medication; acute medical or surgical interventions; underlying
medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.
b) A documented risk benefit assessment, following the resident assessment

by the
interdisciplinary team, where bed rails are in use. The documented risk benefit
assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.
c) Documented approval of the use of bed rails for an individual resident by the
interdisciplinary team that conducted the resident's assessment and the final risk benefit
assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/reassessment by
the interdisciplinary team. Consider the factors referenced with regards to the sleeping
environment assessment, the treatment programs/care plans section and the risk
intervention section of the prevailing practices document "Clinical Guidance for the
Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care. The written plan of care is to reflect the assessed use and position of bed rails with intermediate locking and stopping positions should these be an assessed needs for residents.

3) Evaluate all resident's bed systems where bed rails are used in the home, in
accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient
Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate

locking and stopping positions are evaluated in all positions as prescribed by the above document.

4) Take immediate corrective action should any bed system not pass entrapment zone
testing. Actions taken are to be in line with the prevailing practices document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (FDA, 2006)".

5) Take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. This includes, but is not limited to:
a) residents' with a bed system that includes an air mattress that cannot pass entrapment zone testing and it has been concluded and documented that the therapeutic benefit outweighs the risk of entrapment, as per the Health Canada guidance document;

Steps to prevent resident entrapment shall be taken in line with the guidance provided in the two FDA prevailing practices documents previously referenced in this compliance
order.

Grounds / Motifs :

1. A review of the home's compliance order plan and actions taken was conducted with the home's DOC RN# 103 , ESM, physiotherapist and the Director of Quality Management.

The following was noted:
The licensee reviewed the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003), "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (FDA, 2006)" and the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". Education on these documents was provided to registered nursing staff

The RN and other registered nurses identified 70 residents out of 213 in the home that used bed rails. The plans of care for residents who were not able to use bed

rails, were revised to identify that bed rails were not to be used. It is also noted that residents who did not use bed rails were not assessed as part of this process and that bed rails are still present on resident bed systems, even when not in use.

The RN and the DOC reported that they developed a "Bed Entrapment Risk Assessment Tool". Training on its use was provided to registered nursing staff. However, the tool's use had not been fully implemented at the time of the inspection. As per the DOC and the RN only a few residents had been assessed with the "Bed Entrapment Risk Assessment Tool" at the time of the inspection.

The ESM and the RN reported that the home purchased a "Bed Entrapment Testing Tool". Training on its use was provided to some registered nursing staff. However, the tool's use had not been fully implemented at the time of the inspection. As per the ESM, only a few resident bed systems had been assessed with the "Bed Entrapment Testing Tool". During further discussion, it was identified that other safety issues related to the use of bed rails were not addressed, including height and latch reliability, as part of their evaluation process.

As such, the home did not meet the ordered requirements as identified in Compliance Order CO #001 issued on February 18, 2021 under inspection report #2021_617148_0005. The ordered requirements were as follows:
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Sources: observations of resident bed systems, review of residents plan of care, Bed Entrapment Risk Assessment Tool, Bed Entrapment Testing Tool use, Interviews with DOC, RN, ESM and physiotherapist [s. 15. (1) (a)]

An order was re-issued by taking the following factors into account:
Severity: There was minimal risk of harm as residents with bed rails in use have not been provided with a resident assessment or bed evaluation in accordance

with prevailing practices.
Scope: The scope of this non-compliance was identified as widespread as it was identified that few residents with bed rails in use has been provided with a resident assessment or bed evaluation in accordance with prevailing practices.
Compliance History: A compliance order was previously issued regarding bed rails under O. Regulation 79/10, s.15(1) in the past 36 months.
(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 229 (4)

The licensee shall ensure that all staff participate in the implementation of the program in relation to the hand hygiene, wearing of personal protective equipment (PPE), availability of PPE supplies at resident rooms and correct infection control signage at resident rooms by completing the following:

1. ensure that all staff do hand hygiene prior to resident care, including prior to and after meal services and during medication administration;
2. ensure that all staff of the LTC home wear appropriate PPE and that the PPE be available at all times when providing resident care and services;
3. conduct audits at least twice weekly, on different shifts, for four (4) consecutive weeks, to assess compliance by staff to established processes and procedures related to hand hygiene, the wearing of PPE, availability of PPE and correct infection control signage; and
4. implement and re-evaluate corrective actions to address any identified deficiencies while ensuring that lessons learned are incorporated into the quality improvement processes and that these be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

It is noted that the home was in a suspected COVID outbreak from June 11 to June 22, 2021.

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

On June 09, 2021, an inspector observed a resident in room. There was an infection control sign for contact precautions at the room door. It was noted that there were no gloves at the room entrance and in the room as part of the available Personal Protective Equipment (PPE) supplies.

On June 14, 2021, a PSW was observed to pass the morning beverage pass in unit's TV Lounge area.The PSW prepared and provided fluid beverage assistance to three (3) residents without performing hand hygiene. The PSW said to the inspector that staff only need to perform hand hygiene before and after beverage passes if they had touched the resident during beverage assistance or had assisted with resident hand and face washing. It was noted that there was a bottle of alcohol-based hand rub (ABHR) on the beverage cart at the time of the beverage pass which was accessible for staff use.

On June 14, 2021, an essential caregiver was observed providing feeding assistance to a resident in their room. The resident was identified to be in isolation as per a PSW and requiring that full Personal Protective Equipment (PPE) be worn during the provision of care. However, no infection control signage was noted to be at resident room entrance.

June 14, 2021, a staff member was observed to not be wearing gloves while providing feeding assistance to a resident. All residents of the unit were under contact and droplet precautions. Staff were to wear full PPE when providing direct care. The staff member said that they were not aware of need to wear gloves as part of contact and droplet precautions when providing feeding assistance. The staff member then proceeded to do hand hygiene and put on gloves for the rest of the resident's provision of care.

On June 14, 2021, a PSW was observed to pass the afternoon snack beverage pass. The PSW prepared and provided snacks and beverages to two residents as well as provided feeding assistance to another resident in the activity lounge without performing hand hygiene. The PSW said to the inspector that they had forgotten to do hand hygiene during the snack pass. It was noted that there was a bottle of ABHR on the snack cart as well as in the activity lounge.

On June 14, 2021, a PSW was observed to pass the afternoon snack beverage pass. The PSW prepared and provided snacks and beverages to four (4) residents

as well as provided feeding assistance to a resident in their room without performing hand hygiene. The PSW was also observed to enter room of a resident that was under isolation precautions without performing hand hygiene prior to donning PPE to enter the room and did not follow correct doffing and hand hygiene procedures after exiting the room. The PSW said to the inspector that they had forgotten to do hand hygiene during the snack pass. It was noted that there was a bottle of ABHR on the snack cart as well as at several locations on the unit hallways.

Discussion held with a unit RPN regarding isolation precautions for a resident. PPE supplies were at the room door entrance but there was no infection control sign. The RPN reported that the identified resident was under droplet and contact precautions, that nursing staff were aware of this. The RPN was not aware that there was no infection control sign at the resident room entrance.

On June 15, 2021, two PSWs were observed by an inspector to be providing feeding assistance to two identified residents respectively. When finished, the PSWs then went to provide feeding assistance to two other residents without doing hand hygiene. It was noted that ABHR was available at several locations in the dining room. Three residents arrived in the unit dining room, sat at their assigned tables and were served their lunch time meal. No hand hygiene was observed to be done by the residents prior to the start of their meal. PSW staff present in the dining room, did not provide hand hygiene assistance for these three residents.

On June 15, 2021, an RPN was observed to do the lunch time medication administration pass. The inspector observed the RPN administer medications to five (5) residents without doing hand hygiene prior to preparing and after administering the medications. It was noted that for all five (5) residents, the administered medication had to be crushed, mixed in apple sauce and administered with the aid of a spoon by the RPN. The RPN reported to an inspector that they forgot to do hand hygiene during the medication pass.

On June 16, 2021 signage for Contact Precautions and door hanging isolation station with gowns and gloves were observed by an inspector outside of an identified resident's room. The signage and PPE were not present on previous tours of the unit on June 8 and 15, 2021. A review of the resident's health care record noted the presence of an infection. The RPN stated that the resident was on contact precautions for care.

Discussion was held on June 14, 2021 with the home's Infection Control Lead. They reported to the inspector that staff are to follow the home's infection control program. The program identifies that any resident who is placed in isolation, needs to have an infection control sign at their room entrance to clearly identify to staff what type of PPE they are to use when providing care to the resident. Staff also need to ensure that PPE supplies are readily available at resident room entrance to facilitate resident provision of care. The Infection Control Lead said that they would follow up with nursing staff to ensure that the correct infection control signs were in place for two identified residents and correct supplies for an identified resident room.

Discussion was held on June 15, 2021 with the home's DOC, Manager of Nursing Care, PSW Supervisor and the home's Infection Control Lead regarding he home's infection control program. The nursing management team acknowledged that staff are not consistently following the home's infection control program such as hand hygiene and correct wearing of PPE. Audits and staff re-education are being done when staff are observed to not be following infection control directives. They have also reached out to the Regional IPAC Team for educational support in May 2021.

As such, staff were not following the home's infection control program, posing infection control risks to residents when the home was in a suspected COVID outbreak.

Sources: Residents health care record, Observations made by the inspectors, Interviews with several PSW staff, three RPNs, DOC, Manager of Nursing Care, PSW Supervisor and the home's Infection Control Lead. [s. 229. (4)]

An Order was deemed to be issued based on the following factors:
Severity of this issue was determined to be an there was actual risk of harm to residents as the home was in a suspected outbreak.
Scope the was deemed to be a pattern as several staff on multiple units were not following hand hygiene and infection control practices as per the home's infection control program
The home has had non-compliance in other sections of the legislation in the past 36 months.

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

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
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:

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
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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
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 3 rd day of August, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LYNE DUCHESNE (117) - (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

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