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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2020	2020_598570_0006	006667-20, 006692-20, 007614-20, 007617-20, 007855-20, 009090-20, 009895-20, 010038-20, 010428-20, 010487-20, 014324-20	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

SAMI JAROUR (570), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 20, 21, 22, 25 - 29, 31, June 1 - 5, 7 - 12, 14 - 19, 21 - 26, 29, 2020.

The following intakes were inspected upon during this Complaint Inspection:
A log #010038-20 related to care concerns.
A log #009090-20 related to a fall incident.
A log #007617-20 related to nutrition and hydration and care concerns.
A log #009895-20 related to infection control program and care concerns.
A log #010487-20 related to care concerns.
A log #007855-20 related to a fall incident and care concerns.
A log #007614-20 related to dining and snack services.
A log #006667-20 related to nutrition and hydration program.
A log #006692-20 related to care concerns.
A log #014324-20 related to a reportable incident.
A log #010428-20 related to the Canadian Armed Forces (CAF) report on observations in Long-Term Care Homes (LTCH) regarding concerns with: infection control, standards of practice and quality of care, supplies, ambiguity of local practices, communications and staffing.

PLEASE NOTE:
- Written Notifications and Compliance Orders (CO) related to LTCHA, 2007, c.8, s. 6. (4) (b) and s. 90. (2) (a), identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.
- Written Notifications and Voluntary Plans of Correction (VPC) related to LTCHA, 2007, c.8, s. 6. (7), s. 8. (1) (b), s. 49. (2) and s. 52. (2), identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.
- Written Notifications related to LTCHA, 2007, c.8, s. 38. (a), s. 89. (1) (a) (i) and s. 107. (4) 2. ii, identified in a concurrent CIS inspection #2020_598570_0005 were issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Senior Executive Director (SED), Director of Care (DOC), Assistant Directors of Care (ADOC), Medical Doctors (MD), Registered Dietitians (RD), RAI-MDS coordinator, Clinical Consultant (CC), Food Service Manager (FSM), Environmental Services Supervisor (ESS), Infection Control Practitioner (ICP), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Family members and residents.

During the course of the inspection, the inspector(s) toured residents' home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A Critical Incident Report (CIR) was submitted to the Director regarding a reportable incident. A related complaint was submitted to the Ministry of Long-Term Care (MLTC).

A review of clinical records including the written plan of care and electronic Medication Administration Record (eMAR) for resident #001 indicated the resident was at a nutritional risk and required a specified intervention including a nutritional supplement.

A review of resident #001's plan of care, directed staff to report any problems with nutritional intake to physician and dietitian.

A review of progress notes for resident #001 indicated, on a specified date, RPN #117 documented that resident #001 had difficulty with nutritional intake and had an identified symptom. On same date, RN #118 documented resident #001 did not tolerate the nutritional supplement well. At a later date, RN #118 documented that resident #001 had difficulty tolerating the nutritional supplement.

During an interview, PSW #104 indicated that RPN #101 asked that if they could give the nutritional supplement to resident #001. The PSW indicated they reported to RPN #101

that resident #001 did not like the supplement and that the resident might not be able to tolerate it. The PSW indicated that the RPN was notified when the incident occurred.

During an interview, registered dietitian (RD) #109 indicated that they were not aware of any concerns of nutritional intake and identified symptoms involving resident #001 as noted in the progress notes. The RD indicated that no referral was submitted for the resident for those concerns.

During an interview, the nursing supervisor RN #113 indicated, upon review of the progress notes for resident #001, no awareness that resident #001 had concerns with nutritional intake and identified symptoms. The RN indicated that registered staff should have notified the physician and send a referral to the dietitian.

During an interview, the Medical Doctor (MD) #119, indicated no awareness that resident #001 had any difficulty tolerating the nutritional intake or resident`s condition as it was not reported or documented in their communication book.

During an interview, the Director of Care (DOC) #125 indicated, upon review of progress notes for resident #001, that both the physician and dietitian should be notified of any incidents of not tolerating nutritional intake. DOC #125, further indicated that it was the responsibility of registered nursing staff to administer the nutritional supplement when ordered in the eMARs to be administered at medication pass.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the development and implementation of the plan of care. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #009’s plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the Director, regarding a fall incident involving resident #009. The CIR indicated the resident was transferred to hospital and diagnosed with an injury.

A review of resident #009’s written plan of care indicated the resident was at risk for falls. The plan of care directed specified interventions for falls prevention and to minimize falls related injuries.

During separate interviews, PSW #142 and RPN #147 indicated when resident #009 fell,

the resident did not have specified falls prevention interventions in place.

During an interview, DOC #125 indicated that resident #009's plan of care was not followed when the resident did not have specified interventions in place.

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #009 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in resident #010's plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated the resident was transferred to hospital and diagnosed with an injury

A review of the CIR documentation indicated a specified falls prevention intervention in place.

A review of resident #010's written plan of care indicated the resident was at risk for falls and required a specified intervention for falls prevention.

During observations of resident #010's room on two separate dates, the specified intervention for falls prevention was not in place.

During separate interviews PSW #141, RPN #111 and RPN 151, they confirmed upon observations that the resident did not have a specified falls prevention intervention in place.

During an interview, ADOC #145 indicated residents at risk for falls would be identified in the care plan and would have a specified intervention in place. ADOC #145 indicated the written plan of care was not followed as a specified falls prevention intervention for resident #010 was not in place.

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #010 as specified in the plan, specific to falls prevention interventions. [s. 6. (7)] (570)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

A CIR was submitted to the Director regarding a reportable incident. A related complaint was submitted to the MLTC.

A review of the CIR indicated registered staff were unable to get a medical device to work when attempted to use for resident #001.

A review of email communication from RN #123 to the DOC and RN #113, indicated that a medical device located in a specified resident home area had no power cord and could not be used.

During an interview, RPN #101 indicated that they could not get the medical device to work, when needed to be used.

During an interview, RPN #102 indicated no awareness if a specified medical device was available on the resident home area where resident #001 resided. The RPN was able to locate the medical device stored in the medication room. The RPN acknowledged that the device was broken and that they would notify a supervisor.

During an interview, RPN #103 indicated that specified medical devices were to be checked by night staff weekly and any concerns would be forwarded to the night supervisor and the infection control nurse. The RPN indicated there was a check list to be completed but that check list had not been used. The RPN further indicated that a medical device on a specified resident home area was checked by a military personal and found that the device did not have enough power to operate.

During an interview, RN supervisor #113 indicated that a month prior to the COVID-19 outbreak, the medical device in a specified resident home area was checked and was not in working condition and that the DOC was informed.

During an interview, DOC #125 indicated that they were aware the medical device on a specified resident home area was not working and that the device was replaced. The DOC further indicated that the night staff did not complete the weekly checklist consistently after checking the medical device during the night shift.

The licensee has failed to ensure that specified medical devices were kept in a good state of repair. [s. 90. (2) (a)] (570)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg 79/10, s. 48 (1) 1. and in reference to O. Reg 79/10 s. 49 (1) the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, that provided strategies to monitor residents.

Under O. Reg 79/10. 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.

Specifically, staff did not comply with the home’s policy “Falls Prevention and Management Program #RC-15-01-01” last updated December 2019, which required nursing staff to implement the post-fall clinical pathway and provide a focused assessment by the “first registered staff person on the scene” and to reassess for possible injury and pain”. Appendix five of the policy, Post Fall Clinical Pathway (last updated August 2019), indicated that staff were to decide to move the resident using a lifting device (following assessment by nurse and approval for transfer).

A CIR was submitted to the Director, regarding a fall incident involving resident #009.

The CIR indicated the resident was transferred to hospital and was diagnosed with an injury.

A review of clinical records for resident #009, indicated the resident was lifted and placed in bed by three staff.

A review of the plan of care for resident #009 indicated the resident required full mechanical lift for transferring with the assistance of two staff.

During an interview, RPN #147 indicated they lifted the resident off the floor with the help of three staff. The RPN confirmed they did not use a lifting device to transfer the resident to bed.

During an interview, DOC #125 acknowledged that the home's policy "Falls Prevention and Management Program" was not followed when resident #009 was transferred to bed without the use of lifting device.

The licensee has failed to ensure that the home's policy for Falls Prevention and Management Program was complied when resident #009 was lifted off the floor without using a lifting device. [s. 8. (1) (a),s. 8. (1) (b)] (570)

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 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 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #010 had fallen, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated the resident was transferred to hospital and was diagnosed with an injury.

A review of progress notes for resident #010 did not indicate that a post-fall assessment was completed when the resident reported to RPN #150 that they had fallen.

A review of the home's policy "Falls Prevention and Management Program #RC-15-01-01", last updated December 2019, indicated nursing staff to implement the post-fall clinical pathway and complete an initial physical and neurological assessment after a resident has fallen. Appendix five of the policy, Post Fall Clinical Pathway (last updated August 2019), indicated that staff were to provide a focused assessment by the first registered staff person on the scene and to reassess for possible injury and pain.

During an interview, RPN #150 indicated they were directed by RN #113 to assess resident #010 for a skin injury. The RPN confirmed that a post-fall assessment was not completed when the resident reported they had fallen.

During an interview, RN #113 indicated they asked RPN #150 to check what was wrong with resident #010 as the resident was noted to have a skin injury. The RN indicated that a post-fall assessment should have been completed for the resident as the resident reported having a fall to RPN #150, was noted to have a skin injury and was complaining of pain.

During separate interviews, DOC #125 and ADOC #145 confirmed that a post-fall assessment was not completed for resident #010 when the resident reported to RPN #150 that they had fallen.

The licensee has failed to ensure that when resident #010 had fallen, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls. [s. 49. (2)] (570)

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 when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate instrument specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #012 received a skin assessment by a member of registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when resident #012 exhibited altered skin integrity in relation to falls.

A complaint was made to MLTC indicated that resident #012 had falls with multiple injuries and was transferred to the hospital on the last fall.

A review of resident #012's clinical records indicated that resident #012 had multiple falls and had skin injuries due to falls. A skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not completed on two identified dates.

In an interview, RN #131 indicated that resident #012 had altered skin integrity on two identified dates, and a skin assessment using a clinically appropriate assessment instrument was not used in conducting a skin assessment.

In an interview, RN #154 who is the Skin and Wound Lead, indicated the expectation for the staff in the LTCH was to complete a skin assessment when a resident exhibited altered skin integrity. RN #154 indicated that resident #012 had altered skin integrity on two identified dates and a skin assessment using a clinically appropriate assessment instrument was not used in conducting a skin assessment.

The licensee has failed to ensure resident #012 received a skin assessment by a member of registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when resident #012 exhibited altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure resident #012, was assessed by a Registered Dietician (RD) who is a member of the staff of the home, when resident #012 exhibited altered skin integrity in relation to falls.

A review of resident #012's clinical records indicated that resident #012 had exhibited altered skin integrity.

In an interview, RN #131 indicated that resident #012 had altered skin integrity, and a referral was not made to the RD according to the homes process.

In an interview RD #109, indicated they did not receive any referrals for resident #012 after resident had exhibited altered skin integrity as a result, the RD did not assess the resident.

The licensee has failed to ensure resident #012 was assessed by a RD who is a member of the staff of the home, when resident #012 exhibited altered skin integrity in relation to falls. [s. 50. (2) (b) (iii)] (762)

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated that the resident reported to RPN #150 of having pain and stated they had fallen. As needed (PRN) pain medication was given to the resident. The resident was transferred to hospital and diagnosed with an injury.

A review of clinical records for resident #010 indicated that RPN #150 recorded resident's pain level and noted that the administration of PRN pain medication was ineffective. The review did not indicate that a pain assessment was completed when the resident complained of pain.

During an interview, RPN #150 indicated they were directed by RN #113 to assess resident #010 for a skin injury. RPN #150 indicated no awareness if resident #010's complaint of pain was a new pain. The RPN indicated that they administered PRN medication for pain which was ineffective, and the resident received another PRN medication for pain. The RPN indicated that a pain assessment should have been completed for the resident.

During an interview, RN #113 indicated when the resident complained of new pain, a pain assessment should have been completed and the resident should have been started on a 72 hrs pain assessment.

During separate interviews, the DOC #125 and the ADOC #145 indicated that the pain assessment should have been completed for resident #010, as the resident was experiencing pain.

The licensee has failed to ensure that when resident #010 complained of new pain that was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument, specifically designed for this purpose. [s. 52. (2)] (570)

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to measure and record resident #003's and #011's monthly weight.

A review of resident #003's clinical record conducted indicated that the resident was not weighed in a specified month.

In separate interviews, RPN #127, RD #109 and PSW #128 indicated that resident #003's weight was not taken or recorded in a specified month.

A review of resident #011's clinical record indicated that the resident was not weighed in a specified month.

In an interview, RPN #121 indicated that resident #011's weight was not taken or recorded in a specified month.

In separate interviews, ADOC #145 and DOC #125 indicated that resident #011's weight was not taken or recorded in a specified month.

The licensee has failed to measure and record resident #003's and resident #011's monthly weight. [s. 68. (2) (e) (i)] (762)

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 ensure the implementation of policies and procedures relating to nutrition care and dietary services and hydration including monitoring and recording of weight on admission and monthly thereafter, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (3) Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities. 2007, c. 8, s. 76. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff have received training within one week of hire.

On March 20, 2020, the Assistant Deputy Minister, Long-Term Care Operations Division of the Ministry of Long-Term Care, issued a memorandum to the sector specific to Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to the COVID-19 Pandemic.

The memorandum and directed the following specific to training:
3. Prioritize the timing of specific training requirements such as Abuse, Infection prevention and Control ensuring those requirements are completed as soon as possible. Training must be provided within one week of the staff member beginning to perform their responsibilities on the following specific topics:
- The Residents' Bill of Rights.
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 24 of the Long-Term Care Homes Act, 2007 to make mandatory reports.
- Fire prevention and safety.
- Emergency and evacuation procedures.
- Infection prevention and control.
All other required training must be provided within three months of the staff member beginning to perform their responsibilities.

During separate interviews, PSW #159, #162, #116, RPN #110 and RPN #147 confirmed that they had no training provided at the LTCH on the above mentioned topics. PSW #116, RPN #110 and RPN #147 indicated they had training on donning and doffing of PPEs and hand hygiene.

During an interview, the DOC #125 confirmed that training was not provided within one week of hire of new staff during the outbreak.

The licensee did not ensure that staff have received training within one week of the staff member beginning to perform their responsibilities. [s. 76. (3)] (570)

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, in case of emergencies or exceptional and unforeseen circumstances, the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drugs are administered to a resident in the home unless the drug has been prescribed for the resident.

A review of resident #015's clinical records on Point Click Care (PCC) indicated that the resident was to receive specified medications.

A review of the medication incident report, indicated, resident #015 was given a specified intervention due to an assessment, however, the resident was not prescribed the specified intervention as an option and no separate order was given by the MD.

In an interview, DOC #125 indicated that resident #015 was given a specified intervention, a medication that they were not prescribed.

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

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

A review of resident #003's clinical records on PCC indicated that the resident was to receive a specified dose of medication at a specified time.

A review of the medication incident report, indicated, resident #003 was given a specified medication at the wrong specified administration time. When RPN #120 was reviewing the medication count, it was noted that the medication for a specified administration time was not given and administered another dose resulting in two doses being given. It was noted by RPN #120 and #121 that two doses of the specified medication were given instead of one.

In an interview RPN #121, indicated when replacing RPN #120 due to an emergency, a medication count was conducted. It was determined, based on the count that resident #003 was given the medication twice. RPN#121 indicated there were no adverse effects as a result of the medication incident.

In an interview DOC#125 indicated that resident #003 was given the medication twice, which resulted in a medication error.

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (762)

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: 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 all staff participate in the implementation of the infection prevention and control program.

During this inspection, Inspector #570 observed the following:

- PSW #159 was in resident #026's room assisting the resident with their drink. The PSW was wearing a cloth mask and goggles. The sign posted on resident #26's door indicated droplet contact precautions and directed staff to wear full PPE including masks, face shield, gown and gloves. The PSW was not wearing a gown while sitting and feeding the resident.
- PSWs #134 and #160 were observed removing their masks while seated at the nursing station in residents' home area.

During an interview, PSW #159 indicated that they would wear a gown when providing care to the resident. The PSW indicated awareness of the posted sign of droplet/contact precautions on resident #025's door. The PSW acknowledged using their own cloth mask due to sensitive skin to the surgical mask provided by the home and indicated not having a replacement, if the mask was soiled.

During an interview, RPN #110, indicated that all staff should follow instructions on the posted signs when entering residents' rooms.

During separate interviews, both PSW #134 and #160 indicated awareness of the requirement to keep the mask on all the time when on the residents' home area.

During an interview, the senior executive director ED #161 indicated staff are expected to use surgical masks supplied by the LTC home and adhere to infection control practices by wearing full PPE, when assisting residents on droplet precautions in their rooms.

During an interview, DOC #125 indicated that staff removing their masks was not acceptable and was not a good infection control practice.

The licensee failed to ensure staff participated in the implementation of the IPAC program, related to observations made of posted additional precautions signs and PPE and universal masking. [s. 229. (4)] (570)

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident or the resident's substitute decision-maker was notified when, the resident required new personal belongings.

During observations of resident #010's room, a mobility device used by resident #010, equipped with a pressure relieving device. The device's cover was noted to be visibly torn with holes.

A review of progress notes for resident #010 did not reveal any communication with resident's SDM regarding the condition of the pressure relieving device cover.

During separate interviews PSW #141, RPN #111 and RPN 151, all confirmed the condition of the device's cover being torn with holes.

During an interview, ADOC #145 indicated that when staff noticed the device's cover was torn, they should follow up and speak with resident's SDM and speak to the Occupational Therapist to get a replacement.

The licensee failed to ensure the resident's substitute decision-maker was notified when, the pressure relieving device's cover used on resident's mobility device required replacement. [s. 38. (a)] (570)

WN #12: 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 resident #010's linens were changed at least once a week and more often as needed.

During observations of resident #010's room, resident #010's bed linens were noted to be visibly soiled with a brown stain for two consecutive days.

During an interview with resident #010, they indicated that the linens were not changed.

During separate interviews RPN #111 and RPN #151, they confirmed the condition of the soiled linen and indicated the linen should have been replaced.

During an interview, ADOC #145 indicated that the home had plenty of linen supplies and that linens should be replaced when soiled.

The licensee failed to ensure resident #010's linens were changed when the linens were noted to be soiled. [s. 89. (1) (a) (i)] (570)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident.

A CIR was submitted to the Director, which stated that resident #009 had sustained a fall. The CIR indicated that the resident was transferred to hospital and was diagnosed with an injury. The CIR did not identify all staff members involved in the incident and had transferred the resident off the floor to bed.

During an interview, RPN #147 indicated the resident was found on the floor and was lifted off the floor with the help of three staff. The RPN indicated they did not use a lifting device to transfer the resident to bed.

During an interview DOC #125 could not identify all staff involved in assisting the resident and acknowledged that the names of all staff involved should have been included in the CIR.

The licensee failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident. [s. 107. (4) 2. ii.] (570)

Issued on this 30th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), MOSES NEELAM (762)
Inspection No. / No de l'inspection :	2020_598570_0006
Log No. / No de registre :	006667-20, 006692-20, 007614-20, 007617-20, 007855-20, 009090-20, 009895-20, 010038-20, 010428-20, 010487-20, 014324-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 27, 2020
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 Valley Farm Road, PICKERING, ON, L1V-3R6

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Jason Gay

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To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (4) (b) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Develop and implement a process to ensure all staff involved in providing care to any resident in the home, collaborate with each other in the development and implementation of the plan of care so that the different aspects of care for that resident are integrated and are consistent with and complement each other.

2. Educate all staff on the home's process to ensure collaboration among staff involved in providing care to any resident in the home.

3. Maintain a record of the above-mentioned process and the education provided, including the content, facilitator, attendees, dates, and times. This record shall be made available to the Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A Critical Incident Report (CIR) was submitted to the Director regarding a reportable incident. A related complaint was submitted to the Ministry of Long-Term Care (MLTC).

A review of clinical records including the written plan of care and electronic Medication Administration Record (eMAR) for resident #001 indicated the resident was at a nutritional risk and required a specified intervention including a nutritional supplement.

A review of resident #001's plan of care, directed staff to report any problems with nutritional intake to physician and dietitian.

A review of progress notes for resident #001 indicated, on a specified date, RPN #117 documented that resident #001 had difficulty with nutritional intake and had an identified symptom. On same date, RN #118 documented resident #001 did not tolerate the nutritional supplement well. At a later date, RN #118 documented that resident #001 had difficulty tolerating the nutritional supplement.

During an interview, PSW #104 indicated that RPN #101 asked that if they could give the nutritional supplement to resident #001. The PSW indicated they reported to RPN #101 that resident #001 did not like the supplement and that the resident might not be able to tolerate it. The PSW indicated that the RPN was notified when the incident occurred.

During an interview, registered dietitian (RD) #109 indicated that they were not aware of any concerns of nutritional intake and identified symptoms involving resident #001 as noted in the progress notes. The RD indicated that no referral was submitted for the resident for those concerns.

During an interview, the nursing supervisor RN #113 indicated, upon review of the progress notes for resident #001, no awareness that resident #001 had concerns with nutritional intake and identified symptoms. The RN indicated that registered staff should have notified the physician and send a referral to the dietitian.

During an interview, the Medical Doctor (MD) #119, indicated no awareness that resident #001 had any difficulty tolerating the nutritional intake or resident`s condition as it was not reported or documented in their communication book.

During an interview, the Director of Care (DOC) #125 indicated, upon review of progress notes for resident #001, that both the physician and dietitian should be notified of any incidents of not tolerating nutritional intake. DOC #125, further indicated that it was the responsibility of registered nursing staff to administer the nutritional supplement when ordered in the eMARs to be administered at medication pass.

The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the development and implementation of the plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk to resident #001. The scope of the issue was isolated at level 1. The home had a level 2 compliance history as they had previous noncompliance with other sections of the LTCHA. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 90 (2) (a) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Prepare an inventory list of all specified medical devices in the home with the locations identified.

2. Ensure all specified medical devices are kept in good repair, maintained and cleaned at a level that meets manufacturer specifications, at a minimum. A record of the schedule of functional checks and cleaning must be kept.

3. Develop and implement an audit process to ensure that all specified medical devices are checked and tested to determine good function, accessible and readily available for use. The auditing process shall include the person(s) responsible for checking specified medical devices and the frequency of the audits. A record of the auditing process must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

A CIR was submitted to the Director regarding a reportable incident. A related complaint was submitted to the MLTC.

A review of the CIR indicated registered staff were unable to get a medical device to work when attempted to use for resident #001.

A review of email communication from RN #123 to the DOC and RN #113, indicated that a medical device located in a specified resident home area had no power cord and could not be used.

During an interview, RPN #101 indicated that they could not get the medical device to work, when needed to be used.

During an interview, RPN #102 indicated no awareness if a specified medical

device was available on the resident home area where resident #001 resided. The RPN was able to locate the medical device stored in the medication room. The RPN acknowledged that the device was broken and that they would notify a supervisor.

During an interview, RPN #103 indicated that specified medical devices were to be checked by night staff weekly and any concerns would be forwarded to the night supervisor and the infection control nurse. The RPN indicated there was a check list to be completed but that check list had not been used. The RPN further indicated that a medical device on a specified resident home area was checked by a military personal and found that the device did not have enough power to operate.

During an interview, RN supervisor #113 indicated that a month prior to the respiratory outbreak, the medical device in a specified resident home area was checked and was not in working condition and that the DOC was informed.

During an interview, DOC #125 indicated that they were aware the medical device on a specified resident home area was not working and that the device was replaced. The DOC further indicated that the night staff did not complete the weekly checklist consistently after checking the medical device during the night shift.

The licensee has failed to ensure that specified medical devices were kept in a good state of repair.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk to resident #001. The scope of the issue was a pattern at level 2 as two identified home areas did not have functional specified medical devices. The home had a level 2 compliance history as they had previous noncompliance with other sections of the LTCHA. (570)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 27, 2020

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

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 27th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

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