Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2015;	2015_286547_0012 (A1)	O-002283-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

The Palace
92 CENTRE STREET ALEXANDRIA ON K0C 1A0

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension for order CO #001 Inspection #2015_286547_0012 Log #O-002283-15. Based on the home's compliance plan, we will grant this request for extension to February 3, 2016 to meet compliance.

Issued on this 18 day of November 2015 (A1)

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

Original report signed by the inspector.

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 6,7,8,9,10,13,14,15,16,17,20- 2015

Log #O-0011578-15 complaint inspection and CI # 2642-000002-15 were conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with several residents, families, President of Resident's Council,President of Family Council, Registered and non-Registered nursing staff, a Physiotherapy assistant, the Activity coordinator, a RAI coordinator, the Director of Care (DOC), Dietary aides, Housekeeping aides, the Handy person, the Environmental Supervisor (ES), the Administrative assistant (AA), and the home's Administrator and a LTC consultant with Extendicare.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 15. (2)	CO #001	2014_289550_0031	547

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	Legendé 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except for as provided for in the regulations.

On July 15th, 2015, the home's Administrative Assistant (AA) provided Inspector #133 the biweekly time sheets for registered staff, for the time period of May 3rd, 2015 – July 25th, 2015.
On May 8th, 2015, there was no RN in the home for the 3pm-11pm shift.

On May 19th, 2015, there was no RN in the home for the 3pm-11pm shift.

On May 24th, 2015, there was no RN in the home for the 3pm-11pm shift.

On June 18th, 2015, there was no RN in the home for the 11pm – 7am shift.

On June 29th, 2015, there was no RN in the home for the 7am – 3pm shift.

On June 30th, 2015, there was no RN in the home for the 7am – 3pm shift.

On July 4th, 2015, there was no RN in the home for the 11pm – 7am shift.

On July 5th, 2015, there was no RN in the home for the 11pm – 7am shift.

Inspector #133 noted that all the above shifts were replaced by an RPN.

On July 10th, 2015, there was no RN in the home for the 7am-3pm shift.
At 8:40am on July 10th, 2015, upon Inspector #545's arrival into the home, the home's RAI coordinator, an RPN, informed the inspector that she was the assigned nurse in charge for the day and that there was no RN in the building at that time. At 10:11 am on July 10th, 2015, a Long Term Care Consultant (LTCC) with Extendicare Assist,

who is also an RN, introduced herself to Inspector #545, indicated that she had recently arrived and was there to work the remainder of the day shift as the RN in the home. Extendicare Assist is the company contracted by the licensee to manage the home. There was no RN in the home from 7-10am.

On July 16th, 2015, the RN shift was covered by RN between 7am – 10am however, an RPN was scheduled to cover the RN shift from 10am – 3pm.

On July 16th, 2015, Inspector #133 discussed the lack of RN coverage for the identified shifts with the Director of Care (DOC). The DOC highlighted that they always ensure that there is at least one registered staff in the building, an RN or an RPN. The DOC confirmed that she was aware of the requirement that there must be an RN on duty and present in the home at all times. The DOC explained that they do not have enough RNs on staff to always cover sick days, statutory holidays and vacation days with other RNs.

The widespread non-compliance described above presents a potential for risk to residents of the home. During the specified time frame, there were nine shifts where the scheduled Registered Nurse (RN) was replaced by a Registered Practical Nurse (RPN) and one shift where the scheduled RN was replaced by an Extendicare Assist Long Term Care Consultant, who is an RN contracted by the licensee. [s. 8. (3)]

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:CO# 001

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #545 observed on July 7, 8 and 9, 2015 a red utility bag in Resident #004's room ,a red lady bug sign (that signifies infection precautions as per the DOC) was observed on the wall above the resident's bed and a Personal Protective Equipment (PPE) cart was observed outside of the resident's shared bedroom. The Contact Precaution sign to alert Residents and Visitors was found inside the third drawer of the PPE cart that indicated to ask a nurse before entering this room.

Inspector #545 reviewed the Resident's health records and noted a late entry progress note for a specified date in March 2015, that indicated a swab of Resident#004's pressure ulcer was done and results indicated positively for infection. A note in the treatment administration record indicated on a specified date in July, 2015 that the pressure ulcer was healed.

In Resident #004's most recent Plan of Care, documented in the Skin Integrity section, that Resident #004 had a Stage 2 pressure wound and to see the treatment binder for dressing change instructions. There was no information regarding any contact precautions for this infection when providing care to the Resident or that the pressure ulcer had healed.

RN #S109 indicated to Inspector #545 on July 9, 2015 during an interview that the Resident had a positive infection status when tested in March, 2015 and should have been added to the care plan and treatment administration record. RN #S109 indicated the pressure ulcer was now healed as of a specified date in July, 2015 and that contact precautions are no longer required. RN #S109 further indicated that the lady bug sign and red utility cart should have been removed from the Resident's room once the pressure ulcer had healed as this is not providing clear direction to staff and others who provide care to Resident #004. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the continence assessment for Resident #005 so that their assessments were integrated, consistent and complemented each other.

Inspector #545 reviewed the resident's health records for February 2015 that indicated that the Resident was occasionally incontinent of bowel and frequently incontinent of bladder, and was on a scheduled toileting plan with use of pads/briefs. A progress note in May, 2015 indicated that the Resident continued to be incontinent of bowel and recommendations made by staff to the DOC and in the shift report and place the

resident on a toileting plan. Seven days later, a Continence Care Assessment was conducted, and it indicated that Resident #005 was occasionally incontinent of bladder and continent of bowels and that a personalized toileting routine with physical assistance was recommended. A note also indicated that the Resident/SDM were aware of the type of incontinent product used within the home, and had voiced agreement to use the available product.

During an interview with PSWs #S111 on July 10, 2015 and #S115 on July 14, 2015 they indicated to Inspector #545 that the Resident was not on a Scheduled Toileting plan, that the Resident wore a brief due to incontinence of bladder and bowel. They both indicated that the Resident toileted independently during the day, that the Resident often threw the soiled brief on the floor in this resident's shared bedroom or bathroom and was unable to put a clean brief independently. PSW #S111 indicated that the brief had plastic tabs and the Resident was able to pull the brief down to use the toilet. PSW #S115 indicated that the brief did not stay up well and that suspenders and/or a belt was needed to hold the resident's pants up which was also identified with a sign above the Resident's bed indicating to put suspenders or belt on. The PSW's indicated that the Registered Nursing staff was aware of this problem, and they no longer reported these concerns.

On July 7, 2015 Inspector #545 noted a lingering offensive odour near Resident #005. On July 6, 7, 8, 9, 10 and 14, 2015, a lingering offensive odour was also noted in the Resident's shared bedroom and in the bathroom.

During an interview with the RAI Coordinator on July 9, 2015 with Inspector #545 she indicated that the Resident had not been on a scheduled toileting plan for over one year and later confirmed as per a review of the Toileting Routine flow sheets and the PSW flow sheets indicated that the Resident self-toileted. The RAI Coordinator indicated that the Resident was taking a stool softener twice daily and that may had contributed to frequent loose bowel incontinence, she further indicated that she would be contacting the physician to review bowel management.

On July 14, 2015 during an interview with the Continence Care Nurse and DOC, they indicated that Resident #005's individualized plan of care to promote and manage bowel and bladder continence was not based on the assessment conducted by the Continence Care Nurse in May, 2015 and the recommendations of Toileting Plan had not been implemented as suggested. She indicated that she completed the quarterly continence care assessments and then made her recommendations to the DOC who decided who should be on the Toileting Program in the home.She further added that

based on her own assessment, Resident #005, should be on a toileting program as Resident #040 was ambulatory with ability to sit on a toilet and required assistance of staff to be reminded due to cognitive impairment. The DOC indicated that if the Continence Care Nurse recommended the toileting program for Resident #005, that it should have been implemented. The DOC further indicated the home would have to review the communication in the nursing department related to resident assessments. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care related to toileting was provided to Resident #043 as specified in his/her plan.

As identified on the critical incident provided by the home to the Director,Resident #043 was toileted in the third floor tub room on a specified date in January, 2015 and left unattended for a short period of time when the resident fell off the commode. Resident indicated to staff to be trying to wipe self when fell off the toilet. The resident was sent to hospital and diagnosed with a fracture.

On July 15, 2015 Inspector #547 reviewed the health records in place on the date of the fall which indicated for toileting, as of October, 2014 that the resident is not to be left unattended on commode. Resident #043 has several medical conditions.

On July 16, 2015 Inspector #547 interviewed the DOC regarding the home's investigation to this critical incident of a fall with injury and indicated that PSW S#121 left Resident #043 alone on the commode, and the careplan specifically indicated that the resident should not be left alone on the commode for toileting. S#121 indicated that she should not have left the resident alone, but thought the resident would be ok for a short period of time.

As such, Resident #043 was not provided the care set out in the plan of care which resulted in a fall with fracture. [s. 6. (7)]

4. The licensee has failed to ensure that Resident #011 toileting plan was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #011 indicated to Inspector #545 during an interview on July 15, 2015 that staff no longer offer the bed pan when changing the resident's brief and that staff changed the brief after lunch when the resident is lying down for a nap. Resident #011

indicated that he/she was still aware being wet or having had a bowel movement. The Resident indicated that he/she did not want to make a fuss or burden staff and was no longer asking for the bedpan.

Inspector #545 reviewed Resident #011's most recent plan of care, that documented in the bladder section that Resident #011 will be dry and comfortable with routine toileting by staff, using medium briefs and that staff were expected to transfer the Resident back to bed, allow use of bed pan, change brief, give pericare and adjust clothing. The bowel section indicated that the Resident was occasionally incontinent but had a regular bowel elimination pattern. The toileting section indicated that Resident #011 will request the bedpan and required two person physical assistance for transfers to bed with mechanical lift for use of bedpan. The resident's health records indicated the resident had several medical conditions including arthritic disease.

PSW #S107 indicated to Inspector #545 during an interview on July 15, 2015 that it had been over one year that Resident #011 had stopped ringing the bell to request to use the bedpan. PSW #S107 further indicated that this resident was aware when the Resident's brief was wet and required to be changed twice on day shift.

On July 15, 2015 RPN #S116 indicated to Inspector #545 that it had been over one year that Resident #011 stopped asking for the bedpan for toileting, and it was no longer used and should likely have been re-evaluated in the care plan.

On July 17, 2015 Inspector #545 interviewed the RAI coordinator, responsible to update the resident's care plans quarterly with MDS, indicated that she was under the impression that staff were offering the bedpan to the resident daily. [s. 6. (10) (b)]

5. The licensee has failed to ensure that Resident #040 was reassessed and the plan of care was being revised because care set out in the plan of care regarding falls prevention had not been effective or different approaches been considered in the revision of the plan of care.

Resident #040 was admitted to the home in April 2011 with several medical conditions, including a neurological condition and impaired vision. The Resident was identified as High Risk for Falls. Resident #040 had several recorded falls during a period between April and June 2015. Post fall assessments were conducted for every incident, however no assessment in the causal factors to any of these falls were documented.

On the following dates,Inspector #545 observed a plastic raised seat (bubble type) with two attached grab bars placed over the toilet bowl in Resident #040's private bathroom: July 8, July 15 and July 16, 2015. Upon pushing on the grab bar closest to the sink, the toilet seat lifted off the toilet bowl.

During an interview the Resident indicated he/she was continent of bladder and bowel, was independent with toileting and didn't like to ask for assistance with transferring to the toilet from his/her wheelchair. The Resident indicated to have had several falls in the bathroom including one where the resident lost balance and the toilet seat fell off the toilet however the toilet seat was never changed.

Upon review of the Resident's health record, it was documented on a specified date in June 2015 that the Resident had fallen in the bathroom and the toilet seat was found on the floor. The Post-Fall assessment indicated that the Resident fell while transferring onto the raised toilet seat from his/her wheelchair. Staff assisted the Resident up into the wheelchair, directed Resident #040 to call for assistance when transferring, and to continue hourly checks.

The most recent Plan of Care indicated that Resident #040 had impaired balance and coordination and required extensive assistance with ambulation and that he/she was non-compliant with requesting of assistance and to ensure call bell was within reach at all times, and to do hourly safety checks.

Inspector #545 interviewed PSW #S117 on July 16, 2015 and indicated that Resident #040 was independent for toileting. She indicated that Resident #040 required assistance in the morning with the transfer from bed to wheelchair and that she checked on the resident at least once per hour and documented it on a High Risk Faller checklist. PSW #S117 indicated that she did not assist the Resident with transfers to the toilet, therefore was unsure how the resident did these transfers.

Housekeeping Aide #S123 tested the raised toilet seat in Resident #040's bathroom and confirmed that the toilet seat was unsafe for use for Resident #040 as he was unable to secure the toilet seat on the toilet bowl. He indicated that the seat was removed daily when the toilet was cleaned and was probably not always secured tightly on the toilet bowl, added that the front plastic knob on the seat had to be turned to just the right spot or else the seat lifted up, making it unsafe for use.

The Environmental Supervisor and the Physiotherapy Assistant indicated to the

Inspector on July 16, 2015 that they were not responsible to assessing what assistive aide was appropriate to the Resident, that it was the responsibility of the Nursing Staff.

On July 16, 2015 RPN #S110 accompanied Inspector #545 to review Resident #040's raised toilet seat. Upon trying to move the toilet seat, the RPN indicated that it shifted from side to side and that it was not properly secured on the toilet bowl. This RPN further indicated that many of these raised toilet seats (bubble type with grab bars) did not fit the toilet bowls properly. She indicated that Resident #040 was never re-assessed for the appropriateness of the assistive device to ensure Resident #040's safety while using it for transferring independently. [s. 6. (11) (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 plan of care sets out clear directions to staff and others who provide direct care to the residents, reassessments conducted when the residents care needs change and that the care set out in those plans of care is provided to residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

On July 6, 2015 Inspector #545 noted the privacy curtain in the shared bedroom #208-1 to be missing two feet of privacy curtain, and Resident #012 indicated that he/she no longer dresses at the bedside, and will go to the bathroom for privacy.
On July 7, 2015 Inspector #545 noted the privacy curtain in the shared bedroom #207-3 to be missing a full curtain panel between both residents who share this room.
On July 8, 2015 Inspector #545 noted the privacy curtain in the shared bedroom #201-1 to be missing a privacy curtain between this resident's bed and the door to the hallway.
On July 8, 2015 Inspector #547 noted the privacy curtain in the shared bedroom #301-1 had a four foot gap along the front of the resident's bed.
On July 8, 2015 Inspector #547 noted the privacy curtain in shared bedroom #214-1 could not be closed across the front of the resident's bed as there were several unused curtain hooks blocking the tract.
On July 8, 2015 Inspector #547 noted the privacy curtain in shared bedroom #216-2 had an unused curtain hook stuck in the tract that would not allow the curtain to be drawn across the front of the resident's bed.

On July 13, 2015 Inspector #547 interviewed the Environmental Manager regarding the resident privacy curtains in the shared bedrooms listed above, and indicated that he had not received any notification via the home's internal communication system for the maintenance department to repair/replace these privacy curtains. The Environmental Manager indicated that he expected that when any staff member should notice a privacy curtain that is missing or not functioning properly to provide resident privacy, that they are to place a note in the home's PM works system that will immediately notify maintenance of the need to repair the area. The Environmental Manager indicated that there is no reason for any missing curtains as he has a box of new curtains in the home ready to be hung. [s. 13.]

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 every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy for each resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On July 13th, 2015, Inspector #133 observed the resident shared bathroom for two resident bedrooms and noted a faint odour of feces. There was no feces in the toilet of this bathroom. There was some feces on the door frame, leading into one of the bedrooms. As well, there was a small piece of feces on the outer garbage can. On July 15th, 2015, Inspector #133 returned to the bathroom with the home's Handy Person. There was no lingering odour. The feces was still on the door frame and on the garbage can, it was darker and dried.

On July 13th, 2015, Inspector #133 observed the visitor bathroom (left) on the main floor. The lower wall to the right of the toilet was dirty with areas of dried red matter and some areas of dried brown matter. The upper left corner of the left toilet paper dispenser was dirty with an accumulation of dried brown matter. Under and to the right of the left toilet paper dispenser, the wall was dirty with areas of dried brown matter. The lower right corner of the light switch plate was dirty with dried brown matter.

On July 17th, 2015, Inspector #133 went into the visitor washroom with the home's Handy Person immediately after it had been cleaned. All areas of concern noted above remained. The Handy Person followed up with the housekeeper and the areas were cleaned.

On July 13th, 2015, Inspector #133 noted that there was a widespread issue with accumulation of small dead insects and spider webs within and around windows in some resident bedrooms and in common areas on the second and third floor units:

-In two resident rooms on the second floor, a heavy accumulation of dead insects was observed between the windows and within the window tracts.
- Within the third floor dining room, at the sliding window closest to the servery, next to a dining room table, the space between the inner and outer windows was observed to be dirty with very heavy accumulation of dead insects, the screens were dirty with accumulation of dead insects, and the outer windows were observed to be dirty with a very heavy accumulation of dead insects and spider webs.
-Within the third floor dining room, at table #1 and #2, the lower outer windows (stationary) were observed to be dirty with very heavy accumulation of dead insects and spider webs and the upper crank out casement window screens were dirty with accumulated dead insects.
-Within the third floor dining room servery, the sliding windows were observed to be dirty with heavy accumulation of dead insects within the tracts, between the windows and on the screens.
-Within the third floor tub room, the light fixture upon entry and the light fixtures above the tub were dirty with accumulation of dead insects.
-Windows in the second floor dining room, facing the front of the home, were in similar condition to the windows in the third floor dining room.
-In the second floor dining room, at the light fixture upon entry to the room, on the ceiling, there was an accumulation of dead insects.
-In the second floor lounge, the windows facing the street were in similar condition to the windows in the third floor dining room, while accumulation on and within and outside of the windows facing the side of the home was not as pronounced.
-In the second floor lounge, the light fixtures were all dirty with accumulation of dead insects, most pronounced in the two closest to the windows facing the street.

It is noted that the inspector did not observe resident bedroom windows on the third floor care unit.

On July 16th, 2015, the home's Environmental Supervisor (ES) informed Inspector

#133 that the outer windows are cleaned once a year in October.

On July 16th, 2015, the Administrator accompanied Inspector #133 for an observational tour of the windows in the second and third floor dining rooms. The Administrator indicated that immediate action would be taken to resolve the situation.

On July 16th, 2015, Inspector #133 went into resident shared bathroom for two bedrooms on the second floor to attempt to measure an open gap, that had been previously observed, between the edge of the floor, behind the toilet, and the wall. There was a raised toilet seat in place on the toilet which hampered the inspector's ability to reach the back area. Inspector #133 removed the raised toilet seat and noted that there was accumulation of brown matter in three areas on the toilet rim which appeared to be corrosion from the screws on the bottoms of the raised toilet seat. The raised toilet seat had a strong odour of urine. Inspector #133 was still unable to reach behind the toilet with the raised seat removed, and therefore the inspector attempted to put the raised toilet seat back on to the toilet. As the seat was moved back and forth, front wards and backwards, a large amount of brown liquid spilled out from the tightening dial at the front of the raised toilet seat. Inspector #133 used paper towels to wipe up the bulk of the brown liquid due to a concern related to the potential for slips and falls, and then sought out the Environmental Supervisor (ES).

Inspector #133 returned to this bathroom with the ES who explained that the raised toilet seats are supposed to be cleaned every day. The ES observed that the toilet rim was dirty, that the raised toilet seat was very odorous, and that it had obviously not been cleaned for a while. Brown liquid continued to drip out as the toilet seat was manipulated. The ES indicated he would follow up with the housekeeper immediately. [s. 15. (2) (a)]

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, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On July 13th, 2015, Inspector #133 observed that the majority of sliding windows in resident bedrooms on the second floor care unit could be opened more than 15 centimetres and one did not have a screen.
Due to an active outbreak of respiratory illness affecting the third floor care unit, the inspector did not observe resident windows on that unit.

-In resident bedroom #217, the right window slid open 27 centimetres (cm) and the left window, which had no screen, slid open 77 cm.
-In resident bedroom #218, the right window slid open 20 cm.
-In resident bedroom #208, the right window slid open 19 cm.
-In resident bedroom #204, the right window slid open 21 cm.
-In resident bedroom #214, the right window slid open 18 cm.
-In resident bedroom #212, the right window slid open 21 cm.
-In resident bedroom #206, the right window slid open 22 cm.
-In resident bedroom #202, the right window slid open 25 cm.
-In resident bedroom #215, there was an air conditioner unit in the right window and the window slid to the left with no restriction.
-In the second floor dining room, at the sliding windows closest to the servery, the right window slid open 17cm.

The sliding windows in resident rooms and in common areas are considered by the home to be the new windows, as per discussion with the Environmental Supervisor. In some resident rooms and in some common areas, the "old" windows consist of a lower stationary window, and an upper crank out casement window.

These crank windows are not restricted and can be opened fully. When fully opened, there is a small open space to the left of the window and a larger open space to the right of the window. On July 15th, 2015, with the assistance of the home's Handy Person, in the second floor dining room, the inspector measured the open space to the right of a fully opened window at 30cm.

These windows are designed in a way that if cranked out past the half way mark, the opener arm comes out of the tract and falls out of place. As a result, the screen has to be removed and the window has to be manipulated to allow the opener arm to be put back into place in the tract. For this reason, Inspector #133 did not measure other crank style windows in their fully open position. All of these windows are of the same design.

On the second floor care unit, Inspector #133 observed this style of window in four resident bedrooms on the second floor. These windows are also in the second and third floor dining rooms, and in resident bedrooms on the third floor care unit.

The height of these windows has been noted, and likely serves to decrease the overall risk presented by the unrestricted windows, particularly in the bedrooms. In the dining rooms, dining room chairs are readily accessible and would provide means for any mobile resident to easily reach such a window.

On July 16th, 2015, Inspector #133 discussed window restrictions with the Environmental Manager (ES). The ES informed that he had revisited every resident bedroom sliding window that morning and restricted them all to open no more than 15cm. The ES informed that he had been considering ways that the crank style windows could be restricted, and that he could not envision a solution given their design. At that time, the ES and the inspector discussed the need for windows in the main floor activity room, the main floor private lounge, and in any other resident accessible areas in the home to be restricted so they open no more than 15 cm as well. The crank out casement window in the private lounge was not restricted, and opened fully to allow for an open space to the right of approximately 30 cm. The base of this window was approximately 115 cm from the floor. A lounge chair is located directly under this window. The ES indicated that the lower windows in the activity

room had not been restricted either. These windows were not measured by the inspector. [s. 16.]

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 every window that opens to the outdoors and is accessible to resident has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: 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 utilize Personal Protective Equipment (PPE) as part of the implementation of the infection, prevention and control program related to respiratory outbreak residents.

On July 7, 2015 the Director of Care informed Inspector #547 that the home's third floor had a respiratory outbreak affecting six residents.

On July 9, 2015 Inspector #547 noted that several PPE bins were located in the third floor hallway and a sign was taped on the top of these bins, to notify all visitors to report to nursing staff for infection control purposes as they need to use mask, gown and gloves with affected residents. No other identifiers were located near the resident's room or bed of the outbreak affecting residents to inform staff and visitors in the home. Housekeeping aide S#105 was cleaning next to Resident #024, identified

on the line listing for the respiratory outbreak for precautions with no PPE. S#105 indicated to Inspector #547 that she was not aware of which resident's had respiratory symptoms. S#105 further indicated that she wore gloves in these rooms for cleaning as equipment used to prevent spread of infection and does not need to wear mask or gown, as she does not work with direct contact with the resident. S#105 was cleaning within 1 meter of Resident #024.

On July 9, 2015 Inspector #547 observed PSW's S#103 and S#104 enter a resident room on the third floor to provide care to an affected resident with no PPE equipment. The same staff members also went into another affected bedroom on the third floor to provide care to the resident, and no PPE equipment was used. Residents in these bedrooms require mask, gown and gloves for respiratory outbreak precautions according to the signs on the respective PPE bins. S#103 and S#104 indicated that it is hard to know who needs the PPE, and who does not, as the bins keep moving down the hall, as another resident on this floor moves them all the time. Inspector #547 noted that the PPE bins on the third floor resident hallway were not located outside the resident rooms requiring the PPE. Inspector #547 then interviewed the following PSW's on the third floor today, S#101, S#102, S#103 and S#104 indicated that the only way to know if someone is on precautions, is to look at the bedside to see the pictogram bug sign and that Resident's currently with the respiratory outbreak wear a yellow bracelet on their wrist.

On July 10, 2015 Inspector #547 observed the line listing for the Respiratory outbreak to include two residents a specified shared bedroom. Inspector #547 noted that no sign located above either of the two residents affected in this room, on the doorway, or any PPE bin outside their room to identify the need for PPE.
Inspector #547 interviewed RN S#113 and RPN S#110 who indicated that the PPE bin should be located outside the resident's bedroom for this shared bedroom, and that the sign taped on the top of the PPE bin should be relocated to the door to identify caution to all visitors and staff to see nursing staff regarding need to wear PPE. Both S#113 and S#110 indicated that both residents in this room should have the pictogram outbreak sign above their beds and on their door for staff and visitors to be aware.

On July 13, 2015 Inspector #547 observed RPN S#100 provide medication to Residents #024 and #046 with identified respiratory precautions and no PPE was utilized. RPN S#100 was located within 1 meter from these residents that were observed to be coughing during their medication administration. Resident #046 also did not have any yellow bracelet to identify that he/she had respiratory outbreak

symptoms to staff or visitors.

On July 13, 2015 Inspector #547 interviewed the DOC, the infection control lead for the home, who indicated that the staff should all be wearing mask, gloves and yellow protective gown when working within a meter of the residents affected by the respiratory outbreak at this time. The home's process was to apply a yellow wrist bracelet to the affected residents, place a pictogram sign above the affected resident's beds, and place a paper with their room number inside the top drawer of the PPE bin for staff to be aware. The DOC indicated that the home currently called the affected resident's POA/SDM when placed on precautions, and a PPE bin was to be located outside the affected resident's room.

On July 14, 2015 Inspector #547 observed the Resident in a specified bedroom on the third floor being assessed for a hearing aide, and an external partner/visitor that came to the home to assess hearing aids indicated that she was not aware of the outbreak in the home. Outbreak notification signs were observed on both front and back doors of the home this morning. Signage is also located on the resident's doorway. This external partner/visitor indicated that she had several residents in the home, and should have asked the nurse when she arrived as to who is affected by the respiratory outbreak. [s. 229. (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 ensure that staff utilize personal protective equipment (PPE) as participation in the implementation of the infection, prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors in a home leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

On July 6, 2015 during the initial tour of the home for the RQI inspection, Inspector #550 observed a half door leading to the servery on the second floor open, unlocked and not supervised at 10:30 by any staff members whereby an operational steam table was very hot to touch from the breakfast meal earlier that day. A resident was noted to be wandering in the dining room with her wheelchair at this time.

Inspector #545 noted on the second and third floors of the home during this same tour that doors to a storage rooms in hallway near bedroom #211 on the second floor and #311 on the third floor, to be unlocked and not supervised by any staff members.

On July 13, 2015 Inspector #547 interviewed the Environmental Supervisor and the Handy Person during a tour of the second floor regarding the unlocked storage rooms and servery doors noted during the initial tour of the home on July 6, 2015. The Environmental Supervisor indicated that these doors should have been locked as each of these doors have their own locking mechanism and the Registered Nursing staff on the units would have a key to access them as required by staff.

The Environmental supervisor indicated that he would review both floors storage rooms and servery doors to ensure that they are locked, and will discuss this with the DOC to review with the nursing staff. [s. 9. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #005 was offered an annual dental assessment and other preventive dental services.

Resident #005 has several medication conditions, as well as cognitive impairment.

On July 10, 2015 Inspector #545 observed Resident #005 had several visible dental issues.

According to the most recent oral assessment conducted by RPN #106 on a specified date in May, 2015 the Resident had dental issues with recommendations documented as follows: the Resident requires assistance with oral/dental care and a referral to the dentist/dental hygienist should be made.

During an interview with RPN #106 on July 10, 2015 she indicated to Inspector #545 that she conducted an Oral Assessment in May 2015. She indicated that she recommended that the Resident be seen by a dentist or dental hygienist. She indicated that she did not discussed her findings and recommendations with the Resident's family, as she thought it was the responsibility of the RAI Coordinator.

On July 10, 2015, the RAI Coordinator indicated to Inspector #545 that she uses the information from the Oral Assessment to complete the RAI-MDS 2.0 assessment. She indicated that she did not contact the Resident's family about the RPN's recommendation as it is the responsibility of the assessor to do.

On July 14, 2015 during an interview with the DOC, she indicated that the home did not offer annual dental assessments, that Multi-Gen (an outside vendor) had stopped coming to the home approximately 4 years ago. The DOC indicated that she was not aware that the home needed to ensure that annual dental assessments are to be offered to Residents. [s. 34. (1) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

On July 16, 2015 at 16:00 and July 17, 2015 at 09:30, Inspector #545 observed a lingering offensive odour in a specified Resident's bedroom on the third floor.

During an interview with PSW #S127 on July 17, 2015, she indicated she was aware of the lingering offensive odour in this bedroom. She indicated that Resident #041 always put the urine receptacle in the garbage by the Resident's bed at night and that it often spilled on the floor and in the small garbage can by the Resident's bed.

On July 17, 2015 Housekeeping Aide #S126, indicated that she was aware of the lingering offensive odour in this bedroom as well and that she used a product called Clorox Urine Remover for Stain and Odour to clean the garbage can and the floor on a daily basis, but that it was not effective in eliminating the odour. She later indicated to the Inspector that while she was away last week, a new product was delivered called: Chemspec Urine Contamination Treatment Spray. She indicated that she had not yet used it as she had concerns with the product because she believed the product to be toxic for the environment but had not discussed this with the Environmental Supervisor yet. [s. 87. (2) (d)]

2. On July 7th and July 8th, 2015, Inspector #545 observed that there was a lingering offensive odour of urine in a specified resident shared bathroom for two resident rooms on the second floor.
On June 13th, 2015, Inspector #133 also observed resident this shared bathroom for these bedrooms and noted there was a lingering offensive odour of urine in the bathroom.

On June 16th, Inspector #133 went into this bathroom with the home's Environmental Supervisor (ES) and there was a lingering offensive odour of urine. The ES indicated this bathroom was known to be problematic with regards to lingering urine odours. It

was noted that the urine odour was strongest around the toilet. Upon closer observation, the Inspector and the ES noted that to the right of the toilet, between the toilet and the wall, there was dried urine on the floor. As well, a piece of floor tile was missing from the back right corner and it could be seen that there was an open gap of approximately 1.5 inches in width and approximately 5 inches in length between the edge of the floor and the baseboard. The area of dried urine extended to this open gap. Following this observation, the floor to the right of the toilet was cleaned, and a piece of floor tile was affixed over the open gap by the ES. Following this intervention by the ES, there was no longer a lingering urine odour in the bathroom.

On June 17th, Inspector #133 obtained the home's written procedure for addressing incidents of lingering offensive odours (Extendicare Housekeeping Policy # HKLD-05-03-08, version September 2013) from the Administrator. The procedure includes a sample odour monitoring tool that is to be used by staff to help identify the source of the odour issues. The inspector asked the Administrator if the procedure had been implemented for the shared bathroom indicated above and he stated that it had not been implemented. He stated that had it been implemented, they would have found the source of the odour and rectified the situation. [s. 87. (2) (d)]

Issued on this 18 day of November 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA KLUKE (547) - (A1)

Inspection No. / No de l'inspection : 2015_286547_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002283-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 18, 2015;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : The Palace
92 CENTRE STREET, ALEXANDRIA, ON, K0C-1A0

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : TERRY DUBE

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan with strategies for achieving compliance to meet the requirement that at least one registered nurse who is both an employee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The plan shall also include all recruiting and retention strategies.

Until such time as compliance is achieved, the licensee shall address the back-up coverage staffing plan in managing absenteeism for registered nurses.

This plan must be submitted in writing to Lisa Kluke,
LTCH Inspector at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569- 9670 on or before August 12, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except for as provided for in the regulations.

On July 15th, 2015, the home's Administrative Assistant (AA) provided Inspector #133 the biweekly time sheets for registered staff, for the time period of May 3rd, 2015 – July 25th, 2015.
On May 8th, 2015, there was no RN in the home for the 3pm-11pm shift.

On May 19th, 2015, there was no RN in the home for the 3pm-11pm shift.

On May 24th, 2015, there was no RN in the home for the 3pm-11pm shift.

On June 18th, 2015, there was no RN in the home for the 11pm – 7am shift.

On June 29th, 2015, there was no RN in the home for the 7am – 3pm shift.

On June 30th, 2015, there was no RN in the home for the 7am – 3pm shift.

On July 4th, 2015, there was no RN in the home for the 11pm – 7am shift.

On July 5th, 2015, there was no RN in the home for the 11pm – 7am shift.

Inspector #133 noted that all the above shifts were replaced by an RPN.

On July 10th, 2015, there was no RN in the home for the 7am-3pm shift.
At 8:40am on July 10th, 2015, upon Inspector #545's arrival into the home, the home's RAI coordinator, an RPN, informed the inspector that she was the assigned nurse in charge for the day and that there was no RN in the building at that time. At 10:11 am on July 10th, 2015, a Long Term Care Consultant (LTCC) with Extendicare Assist, who is also an RN, introduced herself to Inspector #545, indicated that she had recently arrived and was there to work the remainder of the day shift as the RN in the home. Extendicare Assist is the company contracted by the licensee to manage the home. There was no RN in the home from 7-10am.

On July 16th, 2015, the RN shift was covered by RN between 7am – 10am however an RPN was scheduled to cover the RN shift from 10am – 3pm.

On July 16th, 2015, Inspector #133 discussed the lack of RN coverage for the identified shifts with the Director of Care (DOC). The DOC highlighted that they always ensure that there is at least one registered staff in the building, an RN or an RPN. The DOC confirmed that she was aware of the requirement that there must be an RN on duty and present in the home at all times. The DOC explained that they do not have enough RNs on staff to always cover sick days, statutory holidays and vacation days with other RNs.

The widespread non-compliance described above presents a potential for risk to residents of the home. During the specified time frame, there were nine shifts where the scheduled Registered Nurse (RN) was replaced by a Registered Practical Nurse (RPN) and one shift where the scheduled RN was replaced by an Extendicare Assist Long Term Care Consultant, who is an RN contracted by the licensee.
(133)

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

Feb 03, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18 day of November 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA KLUKE - (A1)

Service Area Office /
Bureau régional de services : Ottawa