Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
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Bureau régional de services de Centre-Est
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 06, 2021	2021_673672_0030 (A1)	009053-21, 009351-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Haliburton
167 Park Street P.O. Box 780 Haliburton ON K0M 1S0

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension of the due date for the compliance action plan under s. 19 (1) to be submitted to the MOLTC until October 10, 2021, and an extension of the compliance due date for the finding under s. 229 (4) to October 15, 2021.

Issued on this 6 th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Oct 06, 2021	2021_673672_0030 (A1)	009053-21, 009351-21	Complaint

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167 Park Street P.O. Box 780 Haliburton ON K0M 1S0

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended 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): August 16-20 and September 1-3, 2021

A Critical Incident System inspection (Inspection #2021_715672_0031) was

conducted concurrent to this inspection. Findings of non-compliance were also issued within that report.

The following intakes were completed during this Follow up and Complaint inspection:

One intake related to following up on the outstanding Compliance Order #001, issued in inspection #2021_887111_0010, regarding s. 23. (1) of O.Reg 79/10 of the LTCHA, with a Compliance Due Date of June 25, 2021.

One intake related to a complaint regarding an allegation of staff to resident abuse, IPAC practices occurring in the home and the internal fall prevention policy.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Quality Lead, Environmental/Housekeeping/Food Services Manager, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Attendants, Housekeepers, Environmental Services Workers (ESW), screeners, essential visitors and residents.

The inspector(s) reviewed clinical health records of identified residents and internal policies related to Fall Prevention and Head Injury Review, Hot Weather management, Prevention of Resident Abuse and Neglect, Medication Administration and Infection Prevention and Control. The Inspector(s) also observed staff to resident and resident to resident care and interactions, medication administration and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **6 WN(s)**
- **0 VPC(s)**
- **6 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.O. 2007, c.8 s. 23. (1)	CO #001	2021_887111_0010	672

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was protected from incidents of neglect.

For the purposes of the Long Term Care Homes Act and the Regulation, Neglect is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A Critical Incident Report was submitted to the Director related to an incident which occurred between resident #002 and RN #107. The CIR indicated that resident #002 was neglected by RN #107, when the resident presented with a health concern and requested staff assistance. PSW #106 attempted to assist resident #002 but immediately noted that the resident's health status was quickly declining, therefore reported to RN #107 that the resident required assistance from a nurse. RN #107 continued to complete the morning medication pass and requested PSW #106 implement an intervention, which was completed. According to the PSW staff, RN #107 did not assess resident #002's vital signs nor complete any physical assessments. Resident #002 was eventually transferred to hospital and pronounced dead a short time later. PSW #106 reported to activity staff member #118 they felt that RN #107 had neglected resident #002's care needs and were very upset about the incident. The allegation was then reported to the Quality Manager and an internal investigation was initiated.

During separate interviews, PSW #106 and the Administrator indicated it was the responsibility of RN #107 to assess the resident and communicate the findings from their assessment with the physician/nurse practitioner. It was not within the PSW role and responsibilities to implement the intervention directed by RN #107 and the RN had neglected their responsibilities related to resident #002.

Review of the internal investigation documentation into the incident indicated that RN #107 did not assess resident #007 and the required assistance was not provided. Review of RN #107's documentation stated they had completed specified assessments, but the internal investigation revealed these assessments had not occurred and video surveillance showed staff interacting with RN #107 at the identified times.

During separate interviews, PSWs #106, #108 and #120 confirmed the incident as stated, confirmed that in their opinion, the resident was in distress and RN #107 did not assess resident #002 when they arrived at the resident's bedroom, which was an identified period of time after the first request for assistance.

By not ensuring that resident #002 was protected from neglect by RN #107, the

resident sustained actual harm of prolonged distress, fear and anxiety.

Sources: Critical Incident Report; internal policy related to zero tolerance of resident abuse and neglect; report related to RN #107 to the College of Nurses of Ontario; internal investigation documentation; resident #002's identified eMAR, physician's orders, progress notes and written plan of care; interviews with PSWs #106, #108, #120, activity staff member #118, the Quality Manager and Administrator. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Three Critical Incident Reports (CIRs) were submitted to the Director related to allegations of staff to resident abuse involving residents #002 and #004; PSWs #106 and #116; RPNs #110 and #117 and RN #107. All CIRs were submitted to the director several days after the alleged incident of abuse had occurred.

Review of the internal policy related to zero tolerance of resident abuse and neglect indicated that anyone who witnessed or suspected abuse or neglect of a resident by another resident, staff or other person must report the incident immediately.

By not ensuring every allegation of resident abuse or neglect was immediately reported, residents were placed at risk of being exposed to further incidents.

Sources: Identified Critical Incident Reports; internal policy related to zero tolerance of resident abuse and neglect; internal investigation notes, educational session and educational attendance records completed related to each of the incidents; internal memo related to resident abuse and neglect; interviews with PSWs #106, #116, RPNs #110 and #117 and the DOC/Administrator. [s. 20. (1)]

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. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

During observations made throughout the home, Inspector noted that hazardous liquid cleaning chemicals, such as 946ml bottles of Oxyvir Tb liquid cleaning chemicals, were accessible to the residents in the home as they were stored in resident bathrooms.

During separate interviews, PSWs, housekeeping staff and the housekeeping manager indicated the bottles of Oxyvir Tb liquid cleaning chemicals were routinely being stored in resident accessible areas which included resident bathrooms. Following the interview, the housekeeping manager indicated the contents of the bottles were hazardous chemicals and should not have been stored in resident accessible areas. The Administrator indicated the cleaning chemicals included hazardous substances and should not have been stored in resident accessible areas such as resident bathrooms.

By not ensuring the liquid cleaning chemicals were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted and interviews with PSWs, housekeeping staff, housekeeping manager and DOC/Administrator. [s. 91.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

On a specified date and time, Inspector observed the treatment cart which stored all of the medicated treatment creams for the residents in the home, parked in the central hallway and left unlocked. The treatment cart was noted to still be unlocked more than one hour later and multiple residents were observed to be wandering in the immediate area. RN #119 indicated the expectation in the home was for the treatment cart to be kept secured and locked at all times when not being accessed by staff.

On a specified date and time, Inspector observed medications left at the bedside of residents #010 and #018. The DOC/Administrator indicated the medications should not have been left at the residents' bedside.

On a specified date and time, the treatment cart was parked in the central hallway, left unlocked and noted to still be unlocked more than 30 minutes later. Multiple residents were observed to be wandering in the immediate area. RPN #124 verified the treatment cart should not have been left unlocked when not in use and immediately locked the cart.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted and interviews with PSWs, RPNs, RN #119 and the DOC/Administrator. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (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 drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber.

A Critical Incident Report indicated resident #002 presented with a health care issue and requested staff assistance. The resident was transferred to hospital and later passed away.

During an interview, PSW #106 indicated resident #002 had been receiving an identified intervention, and while the resident was still in the home waiting to be assessed, RN #107 provided direction for PSW #106 to alter the intervention, which was completed. Review of resident #002's progress notes verified the resident had been receiving the identified intervention.

Review of the physician's order and electronic Medication Administration Record (eMAR) indicated resident #002 had an order for an identified intervention, as required, with specified instructions how to implement the intervention. During separate interviews, RPN #110 and the DOC/Administrator indicated resident #002 should not have received the identified intervention as it had been implements as it should have been implemented according to the directions in the physician's order.

By not ensuring resident #002 received the identified intervention in accordance with the directions for use specified by the prescriber, the resident was placed at risk of serious negative side effects occurring.

Sources: Resident #002's identified eMAR, physician's order and progress notes; internal policy related to medication administration and interviews with RPN #110 and the DOC/Administrator. [s. 131. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 the staff followed the home's infection prevention and control (IPAC) practices.

During observations conducted in the home, Inspector observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Some staff were not observed completing hand hygiene between assisting/serving residents during meals and/or nourishment services.

- There were multiple residents in the home with contact/droplet precautions in place. Inspector noted that some of the PPE stations were missing one or more of the required PPE items, such as gowns, gloves and/or eye protection on several occasions.

- PSW #113 was observed in resident #010's bedroom, who had contact precautions in place, assisting the resident with activities of daily living (ADLs) but did not have any PPE in place. During an interview, PSW #113 indicated resident #010 no longer required the contact precautions. RPN #110 and the Administrator later indicated that resident #010 did require contact precautions to be followed at all times, and PSW #113 should have donned the required PPE prior to assisting resident with ADLs.

- PSWs #104 and #111 were observed in resident #011's bedroom, who had contact/droplet precautions in place. The PSWs were observed to don/doff their PPE in an incorrect sequence and wearing their PPE incorrectly, such as double masking.

- Staff were observed assisting residents who had contact/droplet precautions in place, but were observed to don/doff their PPE in an incorrect sequence and/or not perform hand hygiene prior to assisting the resident.

- Resident #007 was observed to be positioned throughout the day at the nursing station and attend the dining room, despite having contact/droplet precautions in place. The resident did have a mask on, but it routinely only covered the resident's mouth, not nose, which was not repositioned by staff.

- On multiple dates, residents were observed to be sitting in common areas without physical distancing and/or wearing masks.

- Resident #013 had contact/droplet precautions in place and had a visitor in their room without wearing any PPE items. RN #119 entered the room to provide medication administration but did not correct the visitor until the lack of PPE items was pointed out by Inspector. RN #119 requested the visitor put on PPE, but did not provide any direction or instruction therefore the visitor did not put on any gloves. RN #119 entered/exited the resident's room without assessing the PPE items worn by the visitor and did not provide any further direction until Inspector requested they provide assistance to the visitor.

- Staff members were observed to be sitting in the nursing station together while not maintaining physical distancing.

- PSW staff members were observed to be walking in the hallways with gloves on.

- PSWs #106 and #121 were observed completing the PANBIO COVID-19 swabbing for a visitor. Following the assessment, PSW #121 was observed doffing the PPE items incorrectly and did not complete hand hygiene.

The observations demonstrated that that there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted and interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Office Manager, Director of

Care/Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

Issued on this 6 th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2021_673672_0030 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009053-21, 009351-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 06, 2021(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Haliburton 167 Park Street, P.O. Box 780, Haliburton, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nik Chandrabalan

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

(A1)
The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

1). Prepare and implement a plan to determine how the home will manage situations when changes of condition happen. The plan must include but not be limited to:
- roles and responsibilities of registered staff in the home
- roles and responsibilities of PSW staff on the in the home
- roles and responsibilities of staff related to administration of oxygen therapy.

Please submit the plan to CentralEastSAO.MOH@ontario.ca, Attention: Jennifer Batten, Inspector #672 by October 10, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 was protected from incidents of neglect.

For the purposes of the Long Term Care Homes Act and the Regulation, Neglect is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction

that jeopardizes the health, safety or well-being of one or more residents."

A Critical Incident Report was submitted to the Director related to an incident which occurred between resident #002 and RN #107. The CIR indicated that resident #002 was neglected by RN #107, when the resident presented with a health concern and requested staff assistance. PSW #106 attempted to assist resident #002 but immediately noted that the resident's health status was quickly declining, therefore reported to RN #107 that the resident required assistance from a nurse. RN #107 continued to complete the morning medication pass and requested PSW #106 implement an intervention, which was completed. According to the PSW staff, RN #107 did not assess resident #002's vital signs nor complete any physical assessments. Resident #002 was eventually transferred to hospital and pronounced dead a short time later. PSW #106 reported to activity staff member #118 they felt that RN #107 had neglected resident #002's care needs and were very upset about the incident. The allegation was then reported to the Quality Manager and an internal investigation was initiated.

During separate interviews, PSW #106 and the Administrator indicated it was the responsibility of RN #107 to assess the resident and communicate the findings from their assessment with the physician/nurse practitioner. It was not within the PSW role and responsibilities to implement the intervention directed by RN #107 and the RN had neglected their responsibilities related to resident #002.

Review of the internal investigation documentation into the incident indicated that RN #107 did not assess resident #007 and the required assistance was not provided. Review of RN #107's documentation stated they had completed specified assessments, but the internal investigation revealed these assessments had not occurred and video surveillance showed staff interacting with RN #107 at the identified times.

During separate interviews, PSWs #106, #108 and #120 confirmed the incident as stated, confirmed that in their opinion, the resident was in distress and RN #107 did not assess resident #002 when they arrived at the resident's bedroom, which was an identified period of time after the first request for assistance.

By not ensuring that resident #002 was protected from neglect by RN #107, the resident sustained actual harm of prolonged distress, fear and anxiety.

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

Sources: Critical Incident Report; internal policy related to zero tolerance of resident abuse and neglect; report related to RN #107 to the College of Nurses of Ontario; internal investigation documentation; resident #002's identified eMAR, physician's orders, progress notes and written plan of care; interviews with PSWs #106, #108, #120, activity staff member #118, the Quality Manager and Administrator.

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

Severity: There was actual harm to resident #002 when their needs were neglected by RN #107.

Scope: The scope of this non-compliance was isolated, as only one resident was affected by the incident.

Compliance History: One previous Compliance Order under the s. 19 (1) legislation was issued to the
home during Critical Incident System inspection #2019_815623_0016 on November 19, 2019, within the previous 36 months. The Compliance Order had a compliance due date of February 28, 2020.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:

1). Re-educate all nursing staff on the internal policy entitled "Zero Tolerance of Resident Abuse and Neglect Program"; policy number: RC-02-01-01; last updated: June 2021. This must include review of the reporting requirements. Keep a documented record of the education completed and make available for Inspector review upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Three Critical Incident Reports (CIRs) were submitted to the Director related to allegations of staff to resident abuse involving residents #002 and #004; PSWs #106 and #116; RPNs #110 and #117 and RN #107. All CIRs were submitted to the director several days after the alleged incident of abuse had occurred.

Review of the internal policy related to zero tolerance of resident abuse and neglect indicated that anyone who witnessed or suspected abuse or neglect of a resident by another resident, staff or other person must report the incident immediately.

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

By not ensuring every allegation of resident abuse or neglect was immediately reported, residents were placed at risk of being exposed to further incidents.

Sources: Identified Critical Incident Reports; internal policy related to zero tolerance of resident abuse and neglect; internal investigation notes, educational session and educational attendance records completed related to each of the incidents; internal memo related to resident abuse and neglect; interviews with PSWs #106, #116, RPNs #110 and #117 and the DOC/Administrator.

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

Severity: There was actual risk of harm to residents possibly being exposed to further incidents of resident abuse and/or neglect.

Scope: The scope of this non-compliance was widespread, as three out of three incidents were not immediately reported.

Compliance History: Within the previous 36 months, one Voluntary Plan of Correction was issued to the home under the s. 20 (1) legislation during Critical Incident System inspection #2021_887111_0010 on June 3, 2021; one Voluntary Plan of Correction was issued to the home under the s. 20 (1) legislation during Critical Incident System inspection #2019_694166_0029 on December 30, 2019; one Written Notification was issued to the home under the s. 20 (1) legislation during Critical Incident System inspection #2019_815623_0016 on November 19, 2019 and one Voluntary Plan of Correction was issued to the home under the s. 20 (1) legislation during Resident Quality Inspection #2018_643111_0017 on December 5, 2018.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

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: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee must be compliant with s. 91 of the LTCHA.

Specifically, the licensee must:

1). Conduct weekly audits of the resident home areas for a four week period to ensure there are no hazardous substances stored in resident accessible areas. Keep a documented record of the audits completed and make available for Inspector review upon request.

2). Educate all staff on what hazardous chemicals are and the importance of ensuring they are not stored in resident accessible areas.Keep a documented record of the audits completed and make available for Inspector review upon request.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

1. The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

During observations made throughout the home, Inspector noted that hazardous liquid cleaning chemicals, such as 946ml bottles of Oxyvir Tb liquid cleaning chemicals, were accessible to the residents in the home as they were stored in resident bathrooms.

During separate interviews, PSWs, housekeeping staff and the housekeeping manager indicated the bottles of Oxyvir Tb liquid cleaning chemicals were routinely being stored in resident accessible areas which included resident bathrooms. Following the interview, the housekeeping manager indicated the contents of the bottles were hazardous chemicals and should not have been stored in resident accessible areas. The Administrator indicated the cleaning chemicals included hazardous substances and should not have been stored in resident accessible areas such as resident bathrooms.

By not ensuring the liquid cleaning chemicals were stored in resident inaccessible areas, residents were placed at risk of possible ingestion and/or exposure to the hazardous substances.

Sources: Observations conducted and interviews with PSWs, housekeeping staff, housekeeping manager and DOC/Administrator.

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

Severity: There was actual risk of harm to the residents as residents had access to the hazardous substances, which could have resulted in possible ingestion and/or exposure to the hazardous substances.

Scope: The scope of this non-compliance was widespread, as there were several bottles left in multiple resident bathrooms throughout the home.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months.

(672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 05, 2021

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: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

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

The licensee must be compliant with section s. 129. (1) (a) of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Ensure that drugs and medicated treatment creams are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, which is kept secured and locked when not in use.

2. Conduct weekly audits of the resident home areas until compliance is achieved, to ensure medications and medicated treatment creams are being stored in an appropriate area or the medication cart as outlined in the regulation. Keep a documented record of the audits completed.

3. Re-educate nursing staff (both Registered and PSWs) to remind them of the requirement for drugs and medicated treatment creams to be stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and the medication and treatment carts are to remain locked when not in use. Keep a documented record of the education provided and staff signatures that education was received and understood.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

On a specified date and time, Inspector observed the treatment cart which stored all of the medicated treatment creams for the residents in the home, parked in the central hallway and left unlocked. The treatment cart was noted to still be unlocked more than one hour later and multiple residents were observed to be wandering in the immediate area. RN #119 indicated the expectation in the home was for the treatment cart to be kept secured and locked at all times when not being accessed by staff.

On a specified date and time, Inspector observed medications left at the bedside of residents #010 and #018. The DOC/Administrator indicated the medications should not have been left at the residents' bedside.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

On a specified date and time, the treatment cart was parked in the central hallway, left unlocked and noted to still be unlocked more than 30 minutes later. Multiple residents were observed to be wandering in the immediate area. RPN #124 verified the treatment cart should not have been left unlocked when not in use and immediately locked the cart.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted and interviews with PSWs, RPNs, RN #119 and the DOC/Administrator.

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

Severity: There was actual risk of harm to the residents as residents had access to medications and medicated treatment creams.

Scope: The scope of this non-compliance was widespread, as there were several resident rooms affected and there were multiple observations of the medication and treatment carts being left unlocked.

Compliance History: One or more areas of non-compliance were issued to the home under different sub-sections of the legislation within the previous 36 months. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2021

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: 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with section s. 129. (1) (a) of O. Reg. 79/10. Specifically, the licensee must:

1. Ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

2. Conduct audits of all residents in the home receiving oxygen therapy to ensure they are receiving the therapy as prescribed. Keep a documented record of the audit(s) completed and make available to Inspector upon request.

3. Re-educate nursing staff (both Registered and PSWs) to remind them of the roles and responsibilities of the PSW and Registered staff when administering oxygen therapy. Keep documentation and make available to Inspector upon request, a record of the education provided and staff signatures that education was received and understood.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber.

A Critical Incident Report indicated resident #002 presented with a health care issue and requested staff assistance. The resident was transferred to hospital and later passed away.

During an interview, PSW #106 indicated resident #002 had been receiving an identified intervention, and while the resident was still in the home waiting to be assessed, RN #107 provided direction for PSW #106 to alter the intervention, which was completed. Review of resident #002's progress notes verified the resident had been receiving the identified intervention.

Review of the physician's order and electronic Medication Administration Record (eMAR) indicated resident #002 had an order for an identified intervention, as required, with specified instructions how to implement the intervention. During separate interviews, RPN #110 and the DOC/Administrator indicated resident #002 should not have received the identified intervention as it had been implements as it should have been implemented according to the directions in the physician's order.

By not ensuring resident #002 received the identified intervention in accordance with the directions for use specified by the prescriber, the resident was placed at risk of serious negative side effects occurring.

Sources: Resident #002's identified eMAR, physician's order and progress notes; internal policy related to medication administration and interviews with RPN #110 and the DOC/Administrator.

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

Severity: There was actual harm to resident #002 and actual risk of harm to the other residents in the home not receiving medications and/or medicated treatments in accordance with the directions for use specified by the prescriber.

Scope: The scope of this non-compliance was isolated, as only resident #002 was noted to have not received their medication in accordance with the directions for use specified by the prescriber.

Compliance History: Previous non-compliance was issued to the home under the same sub-section of s. 131 (2) of the legislation within the previous 36 months. A Voluntary Plan of Correction was issued to the home in Complaint inspection #2019_694166_0028, issued on December 30, 2019; a Voluntary Plan of Correction was issued to the home in Complaint inspection #2018_643111_0026, issued on January 15, 2019; and a Written Notification was issued to the home in Resident

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

Quality Inspection #2018_643111_0017, issued to the home on December 5, 2018. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021

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: 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision from the management team to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of the management assignments to be out on the resident home areas and make available for Inspectors, upon request.

2. Conduct daily hand hygiene audits for a period of two weeks, especially around meal and nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Keep a documented record of the audits completed and make available for Inspectors, upon request.

3. Conduct daily audits of PPE donning/doffing and usage to ensure PPE is being utilized, donned and doffed as required, until compliance is achieved. Keep a documented record of the audits completed and make available for Inspectors, upon request.

4. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the education, training and audits completed and make available for Inspectors, upon request.

5. All PPE caddies must be fully stocked and have appropriate PPE items in them.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

During observations conducted in the home, Inspector observed the following:

- No hand hygiene was offered/performed on residents prior to or following food

and/or fluid intake during meals or nourishment services.

- Some staff were not observed completing hand hygiene between assisting/serving residents during meals and/or nourishment services.

- There were multiple residents in the home with contact/droplet precautions in place. Inspector noted that some of the PPE stations were missing one of more or the required PPE items, such as gowns, gloves and/or eye protection on several occasions.

- PSW #113 was observed in resident #010's bedroom, who had contact precautions in place, assisting the resident with activities of daily living (ADLs) but did not have any PPE in place. During an interview, PSW #113 indicated resident #010 no longer required the contact precautions. RPN #110 and the Administrator later indicated that resident #010 did require contact precautions to be followed at all times, and PSW #113 should have donned the required PPE prior to assisting resident with ADLs.

- PSWs #104 and #111 were observed in resident #011's bedroom, who had contact/droplet precautions in place. The PSWs were observed to don/doff their PPE in an incorrect sequence and wearing their PPE incorrectly, such as double masking.

- Staff were observed assisting residents who had contact/droplet precautions in place, but were observed to don/doff their PPE in an incorrect sequence and/or not perform hand hygiene prior to assisting the resident.

- Resident #007 was observed to be positioned throughout the day at the nursing station and attend the dining room, despite having contact/droplet precautions in place. The resident did have a mask on, but it routinely only covered the resident's mouth, not nose, which was not repositioned by staff.

- On multiple dates, residents were observed to be sitting in common areas without physical distancing and/or wearing masks.

- Resident #013 had contact/droplet precautions in place and had a visitor in their room without wearing any PPE items. RN #119 entered the room to provide medication administration but did not correct the visitor until the lack of PPE items

was pointed out by Inspector. RN #119 requested the visitor put on PPE, but did not provide any direction or instruction therefore the visitor did not put on any gloves. RN #119 entered/exited the resident's room without assessing the PPE items worn by the visitor and did not provide any further direction until Inspector requested they provide assistance to the visitor.

- Staff members were observed to be sitting in the nursing station together while not maintaining physical distancing.

- PSW staff members were observed to be walking in the hallways with gloves on.

- PSWs #106 and #121 were observed completing the PANBIO COVID-19 swabbing for a visitor. Following the assessment, PSW #121 was observed doffing the PPE items incorrectly and did not complete hand hygiene.

The observations demonstrated that that there were inconsistent IPAC practices from the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted and interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Office Manager, Director of Care/Administrator.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Voluntary Plan of Correction was issued to the home under legislative reference r. 229 (4) during Critical Incident System inspection #2021_887111_0010, which was issued to the home

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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

on June 3, 2021. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 15, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Ontario

Ministry of Long-Term Care

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Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6 th day of October, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JENNIFER BATTEN (672) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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