**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 11, 2018 | 2018_759502_0012 | 018339-18 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON  N2E 4H5

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

Fairview Nursing Home
14 Cross Street TORONTO ON  M6J 1S8

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

JULIENNE NGONLOGA (502), CECILIA FULTON (618), VERON ASH (535)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 20, 23, 24, 25, 26, 27, 30, 31, August 1, 2, 3, 7, 8, 9, 10, 13, 31 and September 5, 2018.**

**During the Resident Quality Inspection (RQI), the following intake was inspected concurrently: log: # 006093-17 related to food quality, staff shortages, housekeeping, and maintenance.**

**During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing (DON), Physician, Pharmacist Consultant, Personal Expression (PE) Lead, Neighbourhood Care Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Scheduling Clerk, Administrative Assistant Coordinator, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Dietitian (RD), Director of Food Services (DFS), Dietary Aide (DA), Environmental Services Manager (ESM), Housekeepers, Social Service Worker (SSW), Residents' Council (RC) president and the Family Council (FC) president, residents, substitute decision-makers (SDMs) and family members.**

**During the course of this inspection, the inspectors toured the home, observed the provision of care, staff and resident interactions, medication administration, and infection prevention and control practices; reviewed the residents' health records, meeting minutes, staff schedules and relevant policies and procedures.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Family Council**
**Food Quality**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

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

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

**WN #1: 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,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).**

**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 were developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Review of a complaint received by the Ministry of Health and Long-Term care (MOHLTC) on an identified date indicated that the complainant expressed concern related to uncleanliness of the home.

On an identified date, during the Resident Quality Inspection (RQI), the inspector observed the following areas in the home which were unclean:

1. On an identified floor in the common areas, the inspector observed light brownish and pinkish red stains on the floor inside the dining room, outside the elevator door and around the outside areas of the nursing station.

The unclean state of the above mentioned areas on the floor were confirmed by staff #119, who stated that the stains could be related to the spills of beverage onto the floor by residents. They indicated that the home’s process was to call housekeeping staff to clean the floors immediately after spillage occurred. Housekeeping staff were notified

immediately after the interview.

2. On identified floors the inspector observed that each floor was in an unclean state with dried and hardened blackish substances collecting in the corners, door jams, around the heating unit pipes, and along the hallway baseboard.

In interviews, housekeeping staff #125 and #126, confirmed the observations noted above. Staff #126 stated that if the floors looked really dirty they would stop and clean it; however, sometimes they might miss cleaning an area because there was so much to get done.

3. An identified resident's room was observed by staff #125 and the inspector. Inside the corners between the wall and the heater were unclean with a dried blackish substance stuck on the floor. The staff verified that the corners on the floor in the resident's room were unclean and needed to be cleaned. The inspector made the same observations in three other identified resident rooms.

During an interview, resident #011 stated that the building was kept unclean, and it was getting worse. They added that a specified floor was especially unclean, that they would prefer to move to another unit if/when the opportunity becomes available.

During an interview, the inspector observed specified floors with the home's Environmental Service Manager (ESM), who confirmed that the areas mentioned above identified during the walk were not properly cleaned, and that a new procedure would be developed and implemented to clean the corners, door jams, around the heating unit pipes, and the baseboards along the hallways. The ESM informed the inspector that the cleanliness of the floors were improved however, they require further treatment and cleaning especially the areas identified above.

Therefore, the home failed to ensure that procedures were developed and implemented for cleaning of the home, including the floors in residents' rooms and common areas. [s. 87. (2) (a)]

2. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Review of a complaint submitted to the MOHLTC revealed that the home was very disgusting and had a foul odour.

During the course of the RQI Inspectors #502 and #566 noted lingering odour of urine in the home.

On an identified date and time on a specified unit, Inspector #502 noted a lingering odour of urine.

Staff #123 stated that the lingering odour was a result of resident #016 being incontinent.

Interview with staff #112 stated that they deep clean resident #016’s room daily as the resident was incontinent on the floor. They indicated that the urine had penetrated inside the tiles and super absorbent and deodorizer and urine neutralizer are used daily to control the lingering odour.

In an interview staff #111 stated that odour of urine was an ongoing problem as the resident continues to be incontinent on the floor and that the home had a plan to change the entire floor. [s. 87. (2) (d)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**7. Every resident has the right to be told who is responsible for and who is providing the resident’s direct care. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident has the right to be told who was responsible for and who was providing the resident’s direct care.

During the interview with the president of the Residents' Council, they indicated that the residents had expressed concern on multiple occasions related to the identification of the staff on duty. They stated that the staff name badges are small and the residents rely on staff names posted on a board to know who is on duty.

According to identified Residents' Council meeting minutes, the residents stated that they were not being introduced to new staff members, explained that the boards on each neighbourhood/floor were not being filled out with staff names on each shift so they didn't know who was working. Also the residents stated that new staff should introduce themselves to residents before providing care.

On an identified date and time the inspector observed that the name of staff on duty were not written on the board on the first and third floor units. The inspector also observed that staff #106 was not wearing their name badge. Staff #106 indicated that their name tag was in their bag and they should have worn it. They confirmed that the white board was not filled out with the names of staff on duty.

On an identified date and time the inspector observed that the names of staff on duty were not written on the board on identified floor units.

Staff #119 confirmed that the white board was not filled out with the names of staff on duty as they did not have a marker.

Staff #114 acknowledged being aware of the residents' concern related to staff identification. Staff #114 indicated that some strategies including the use of white boards, staff to wear name tags, and introduction of new staff during Residents' Council meeting. However they acknowledged that the responsibility of writing the staff names on the white board was not assigned, and that more needed to be done to ensure that residents are aware of the staff working on the unit. [s. 3. (1) 7.]

2. The licensee has failed to ensure that the right of every resident to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible was respected and promoted.

During stage two of the RQI, resident #005 triggered for worsening behaviour from the previous-most recent minimum data set (MDS) assessment.

Review of the progress notes revealed that on an identified date, the social service worker (SSW) sat with resident #005 for two hrs in the courtyard to calm them down and prevent eloping. Approximately one hour after the SSW returned inside the building, resident #005 who was unsupervised at the time walked away from the building.

On multiple occasions throughout this inspection, the inspectors observed the residents of the home sitting in the outdoor areas in the courtyard unsupervised. Further observation of the outdoor areas revealed that the courtyard's gate was wide open and did not have a locking mechanism.

In an interview staff #114 acknowledged that the outdoor areas were not secured. [s. 3. (1) 26.]

***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 residents right to be told who is responsible for and who is providing the resident's direct care is fully respected and promoted, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

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

**s. 6. (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 staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

During stage two of the RQI, resident #005 triggered for worsening behaviour from the previous-most recent MDS assessment.

Review of the MDS assessment completed on an identified date, indicated that resident #005 was modified independent and had memory impairment due to specified diagnosis.

Review of the MDS assessment and the resident's current written plan of care indicated that resident exhibits specified responsive behaviours.

Review of the eMAR for a three month period, revealed that resident #005 had continuously refused their scheduled medications except on identified days during the above mentioned three month period.

Review of the progress notes for the above mentioned three month period indicated the physician was aware that resident #005’s refusals of care and they documented the following:
- resident did not want any interventions and wishes nature to take takes its course,
- they are treating as best as possible to keep the resident comfortable. The physician further wrote that they feel the resident completely understands the risk, and very religious, just wants nature to take its course,
- resident #005 simply wants to be left to their own, to be comfortable, and was refusing care,
- they resident wants end of life care and we are supporting them as much as possible as is the family.

Review of the resident's Advance Care Planning Individual Summary signed by resident #005's POA on an identified date indicated under code status, full code- attempt cardiopulmonary resuscitation (CPR).

In separate interviews, staff #100 and DOC #115 indicated that when a resident expresses a desire for end-of -life care, a care conference with the resident, family, and the multidisciplinary team including the attending physician will take place; the advance directives will be reviewed and changed to palliative care, based on the resident wishes.

The staff acknowledged that they did not have a care conference as they were not aware that the resident wanted end-of -life care. They acknowledged that the physician had not collaborated with the team as they had not shared their assessment with the rest of the team. [s. 6. (4) (a)]

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

During stage one of the RQI resident #010 triggered from the home’s MDS assessment related to an identified diagnosis.

Health record review indicated resident #010 was assessed by the attending physician on an identified date, related to ongoing symptoms. The primary physician ordered a specified assessment to rule out a specified condition at that time. Four days later the result of the specified assessment mentioned above indicated the resident had a

specified medication condition and the physician wrote an order for a specified treatment that was to be administered every eight hours for an identified period of time; then repeat the specified assessment mentioned above to be taken post treatment.

A review of the progress notes indicated the specified treatment was completed within seven days. The resident was stable with no current signs or symptoms related to the medical condition mentioned above.

During an interview, staff #118 indicated that the above mentioned specified treatment was completed and verified that the resident did not receive the post treatment assessment ordered by the physician, as evidenced by the lack of documentation of the completed assessment in the diagnostic sign-in book kept on the unit. No post treatment assessment result found in the resident's chart, and no documentation in the progress notes by registered staff to reflect the completion of the post treatment assessment mentioned above. Therefore, the home failed to ensure staff and others involved in the different aspects of care collaborated with each other in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complemented each other. [s. 6. (4) (b)]

3. The licensee has failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

During stage two of the RQI, resident #005 triggered for worsening behaviour from the previous-most recent MDS assessment.

Review of the MDS assessment completed on an identified date indicated that resident #005 was modified independent and has memory impairment due to specified diagnoses.

Review of the MDS assessment and resident #005's current written plan of care indicated that resident exhibits identified responsive behaviours.

Review of the MDS included in the resident's application for admission to the home, indicated that resident #005 exhibits similar responsive behaviours and requires specified alternative interventions.

Review of the eMAR for an identified period of time indicated that resident #005 refused

their treatment during the above period except on five occasions.

Review of the quarterly medication review for resident #005 indicated that the resident's medication assessment was completed on an identified date and no recommendation was made.

Review of resident #005's current written plan of care under an identified focus indicated specified interventions.

Review of the resident's progress notes indicated that on an identified date the nurse noted that resident #005 had removed a specified device and continued to exhibit a responsive behaviour mentioned above.

In separate interviews, staff #108 and #100 stated that the resident did not have the specified device for an identified period of time as they refused to have their whereabouts tracked. Staff #100 also indicated that the home had not implemented an additional specified intervention as they had not applied for the high intensity needs funds through the ministry of health. They acknowledged that different approaches were considered when the resident declined to have specified device mentioned above. [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:***
***- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, and are consistent with and complement each other,***
***- staff and others involved in the different aspects of care of the resident collaborate with each other 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, and***
***- If the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff the home on duty and present at all times unless there was an allowable exception to this requirement.

The MOHLTC received a complaint related to insufficient staffing.

On an identified date during the RQI, the inspector requested and reviewed the home’s nursing and personal support services program staffing plan which includes PSWs, RPNs, and RNs. The document indicated there were four shifts missing RN coverage over a period of six months. The identified shifts were missing at least one RN who was an employee of the licensee and a member of the regular nursing staff on duty:

During an interview, staff #102 provided the requested documents indicating the shifts mentioned above that did not have an RN present in the building, and explained the process used by the home related to staffing replacement. According to the scheduling clerk, the home’s DON provided RN coverage for all missing shifts including day, evening and night shifts.

During an interview, the DON confirmed the information above and verified that they worked as the RN providing coverage in the building during all shifts when an RN was not available. Therefore, the licensee failed to ensure there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement. [s. 8. (3)]

***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 there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 were maintained in a safe condition and in a good state of repair.

On an identified date and time in the main kitchen, the inspector observed water dripping from the ceiling above the dish machine onto the clean dishes. Further observation revealed that the ceiling was brown and the paint on the wall around the area was peeling.

Review of a report provided by the ESM indicated that the panel from the ceiling was removed and a wide range of condensation in the ceiling was noted. They noted a pipe with a pin hole spraying steam and that the brown stains were coming from rusty pipes that made it appear as mildew due to water pipe dust. The dish machine was shut off immediately, the area was contained and disposable dishes and cutlery were used.

Review of the maintenance log did not include documentation about the above mentioned area in the main kitchen above the dish machine.

In separate interviews, staff #122 and the Director of Food Services (DFS) stated that the area above the dish machine had been leaking for at least three months.

In an interview, staff #111 stated that the area identified above had water dripping from the ceiling which led to the ceiling turning brown, and they were unaware that the area was not in good condition prior to the inspector bringing that to their attention. [s. 15. (2) (c)]

***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, its furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

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

**s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

**s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that menu substitutions were documented on the production sheet.

According to a complaint submitted to the MOHLTC, the food served to the residents was cold, hard and over cooked. The complainant also alleged that the home was running out of food supplies in the dining room.

Review of the menu cycle record provided by the DFS, indicated that on identified dates beef casserole was substituted with roasted beef and mashed potatoes, and potato salad was substituted with coleslaw. Review of the production sheets did not identify the above substitutions made on the menu.

In an interview, the Director of food services stated that they had not written the above mentioned substitutions made on the production sheets as they were not aware of this legislative requirement. [s. 72. (2) (g)]

2. The licensee has failed to ensure that records were maintained of all menu substitutions, and kept for at least one year.

According to a complaint submitted to the MOHLTC, the food served to residents was cold, hard and over cooked. The complainant also alleged that the home was running out of food supplies in the dining room.

Review of the home's Fall/Winter menu cycle week 2, Wednesday; and Spring menu cycle week 3, Thursday, indicated that the planned menu items for dinner were substituted with cultural menu items. Review of the production sheet record provided by the DFS did not include the production sheets for the cultural menu items offered to the residents for an identified period of time.

In an interview, the DFS stated that they were not maintaining the record of all menu substitutions as they were not aware of the legislative requirement. [s. 72. (4) (c)]

3. The licensee has failed to ensure that the home has and that the staff of the home comply with a cleaning schedule for all the equipment.

During an interview, the president of the Residents' Council indicated that the food service carts were dirty.

On an identified date, after a specified meal service, the inspector noted stains, dirty black dust and food debris inside the microwave on the second floor, on the bottom and around the steam carts on the first and third floors, and inside the vegetables freezer and the refrigerator.

Review of the Cleaning Schedule for an identified month, indicated that the equipment mentioned above are to be cleaned once per week, and they were checked as being clean for the last time during an identified week.

In an interview, the DFS stated that the equipment mentioned above are to be cleaned once a week and they missed cleaning them during an identified  week.They also stated that all equipment that were not assigned to the cleaning duties shift, were to be cleaned by cooks and dietary aides. They acknowledged that staff did not comply with the cleaning schedule as the equipment mentioned above were not cleaned as per the schedule. [s. 72. (7) (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***
***- menu substitutions are documented on the production sheet***
***- records are maintained of all menu substitutions, and kept for at least one year, and***
***- the home has and that the staff of the home comply with, (b) a cleaning schedule for all the equipment, to be implemented voluntarily.***

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**WN #7: 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 residents in accordance with the directions for use specified by the prescriber.

During stage one of the RQI the inspector completed the mandatory medication inspection protocol by first reviewing the home’s medication incident log. After reviewing the medication incident report for resident #008, the resident sample size was expanded to include the two previous medication incidents.

The following medication orders were written by the physician practising in the home, and all medications prescribed were not administered to each resident in accordance with the directions for use specified by the prescriber:

Medication Incident #1 - On an identified date, the physician changed the order of resident #008's specified medication from one identified time of day to another identified time of day. The medication order was not transcribed and entered into the resident’s

electronic medication administration record (eMAR) until three days later, when the Medi-System pharmacist returned to work.

Registered staff working on identified shifts continued to administer the above mentioned medication at the first identified time of day that the physician ordered it for instead of the new time as reflected on the signed resident's eMAR. The previous order was not discontinued, and the new order was not entered in the eMAR system by registered staff.

On an identified date, the resident experienced a negative effect when a specified assessment was completed prior to an identified treatment; the identified medication was held; and then administered to the resident 24 hours later.

On an identified date, the physician ordered a specified medication for resident #008's for an identified period of time. The medication was not transcribed and entered into the eMAR system until three days later, when the pharmacist returned to work. Registered staff working during the period of time mentioned above did not administer the medication as prescribed; therefore causing a missed medication incident which was not captured by the home's medication incident management system.

Medication incident #2 - On an identified date, the on-call physician ordered resident #014 a specified medication twice daily (BID) for an identified period of time. The medication was not transcribed and entered into the eMAR system until a day later, when the pharmacist returned to work.

Registered staff working all shifts during the above identified period of time, did not transcribe and administer the medication to the resident as prescribed by the physician. The resident passed away three days later at the home. The death certificate listed a specified medical condition as cause of death; with other significant conditions contributing to the death.

Medication incident #3 - On an identified date, the physician ordered resident #015 a specified medication for an identified period of time for a specified condition. On an identified date, the registered staff administered a double dosage of the medication mentioned above. The resident experienced no ill effects related to the incident.

During an interview, the home's DON verified the information above and stated that they discussed the incidents with the registered staff involved in each incident with

consequences set in place for their actions. Therefore, the home has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**s. 135. (3) Every licensee shall ensure that,**
**(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).**
**(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).**
**(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the

resident and the pharmacy service provider.

During stage one of the RQI the inspector completed the mandatory medication inspection protocol by first reviewing the home's medication incident log. Thee medication incidents were reviewed as follows:

Medication incident #1 – on an identified date, the physician ordered resident #008 a specified medication to be administered at one identified time of day instead of another. The medication was not administered to the resident as prescribed. The medication incident was not reported to the resident's SDM as verified by the DON.

Medication incident #2 – on an identified date, the on-call physician ordered resident #014 a specified medication for an identified period of time. The medication was not administered to the resident as prescribed. The medication incident was not reported to the resident's SDM as verified by the DON.

Therefore, the home failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision-maker as verified by the home's DON. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective actions were taken as necessary; and a written record was kept of everything required under clauses (a) and (b).

During stage one of the RQI the inspector completed the mandatory medication inspection protocol by first reviewing the home's medication incident log; and the three most recent medication incidents were reviewed.

During an interview, the home's DON verified the following related to the three incidents: Medication incident #1 and #2 were documented using the current electronic medication administration records (eMAR) in point click care (PCC); however, the incidents were not reviewed or analyzed with corrective action taken as necessary and there were no written records kept of the review, analysis and corrective actions. Medication incident #3 was documented on paper (prior to the implementation of the eMAR system); and the comments/corrective actions to prevent occurrence were completed by the DON. The DON documented that staff reviewed the eight (8) medication rights according to the College of Nurses of Ontario before giving medications. However, the incident was not

reviewed and signed by the pharmacist, and there was no further review analysis or corrective actions recorded.

Therefore, the home failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective actions were taken as necessary, and a written record was kept of everything required under clauses (a) and (b). [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented, and a written record was kept of everything provided for in clause (a) and (b).

This inspection was initiated as a result of the review of the home medication's management system. On an identified date, the DON verified the following information related to the three medication incidents:
- medication incidents #1 and #2 were discussed during the quarterly Professional Advisory Committee meeting and documented in the identified minutes,
- medication incidents #1 and #2 were captured in the meeting minutes,
- corrective actions to reduce or prevent medication incidents occurrence in the future were not discussed,
- changes and improvements were not identified, and
- actions were not implemented related to the same.

The DON was unsure if medication incident #3 was discussed or documented at the preceding quarterly Professional Advisory Committee meeting since the minutes for that meeting could not be located. Therefore, the home failed to provide written records which captured the home’s actions for reducing or preventing further medication incidents occurrence, any changes and improvements identified; and implemented actions related to the three medication incidents. There was no adverse drug reaction reported by the home. [s. 135. (3)]

***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 medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider,***
***- all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective actions are taken as necessary; and a written record is kept of everything required under clauses (a) and (b), and***
***- a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

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

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

As part of the mandatory task during RQI, the Residents' Council meeting minutes in the home were reviewed and the following concerns were raised:
- on an identified date, the residents stated that they continued to feel rushed during meal services particularly in the main dining room. Staff would pile the food on the table (soup, main dish, and desert) because they did not want to go back and forth,
- on an identified date, some residents stated that their care needs were not being met, beds were not made in a timely manner, new clothes were not labelled at the same time. Some were not told when medications were discontinued, and that residents continued to feel rushed during meal services; to maintain a positive dining experience, they needed more time.

Review of email communication provided staff #113 indicated that an email was sent by the GM to the team on an identified date in response to the concerns identified above. This was 39 days after the meeting mentioned above.

In separate interviews, staff #113 and #114 stated that after the Residents' Council meetings identified above, staff #113, who was the assistant designated for the council had emailed those concerns to the GM within 72 hours. The GM in consultation with the appropriate department had formulated the response, which was printed and posted on the board on an identified date, and then informed the Residents' Council that the response was posted on the board and the response had also been discussed during the next meeting.

In an interview, the president of the Residents' Council told the inspector that the home was good at getting back to them within 10 days, however the response was always verbal. [s. 57. (2)]

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**WN #10:  The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

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

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

**s. 229. (5) The licensee shall ensure that on every shift,**
**(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

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

On an identified date, during lunch service Inspector #502 observed staff #104 removing dirty dishes from dining room tables, and then they proceeded to serve hot beverage and deserts to the residents without performing any type of hand hygiene.

In an interview staff #104 told the inspector that the home expected staff to wash their hands with soap and water before the beginning of each meal service and to use the hand sanitizer every time they served food to the residents. They confirmed that between removing dirty dishes, and serving dessert to the residents they had not washed their hand or used the hand sanitizer.

In an interview, staff #121 stated that the home's expectation was to complete hand hygiene between tasks during meal service and acknowledged that staff #104 should have sanitized their hands after removing the dirty dishes and before serving the desert to the residents. [s. 229. (4)]

2. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

During stage two of the RQI resident #008 triggered for respiratory infection from most recent minimum data set (MDS) assessment filed.

According to the physician's notes, the attending physician assessed resident #008 on an identified day and noted specified symptoms. They assessed the resident as having a specified medical condition, prescribed a specified medication for an identified period of

time and ordered a specified assessment.

Review of the Infection Control Daily Surveillance Form for an identified month, indicated that resident #008 had a symptom mentioned above on an identified date, and was on a specified treatment.

Review of the progress notes indicated that symptoms of infection were not recorded on five shifts.

In separate interviews staff #100, #115, and #121, indicated that the resident's symptoms of infection in residents are monitored and documented on each shift on the progress notes. Staff #121 acknowledged that the symptoms of infection for resident #008 were not recorded on the dates mentioned above. [s. 229. (5) (b)]

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**Issued on this 23rd day of October, 2018**

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

**Original report signed by the inspector.**

Ministry of Health and Long-Term Care

Ministére 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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

**Public Copy/Copie du public**

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JULIENNE NGONLOGA (502), CECILIA FULTON (618), VERON ASH (535) |
| **Inspection No. / No de l'inspection :** | 2018_759502_0012 |
| **Log No. / No de registre :** | 018339-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 11, 2018 |
| **Licensee / Titulaire de permis :** | Schlegel Villages Inc.<br>325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5 |
| **LTC Home / Foyer de SLD :** | Fairview Nursing Home<br>14 Cross Street, TORONTO, ON, M6J-1S8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Saurabh Bhatnagar |

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

**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

**Order / Ordre :**

The licensee shall prepare and submit a plan to ensure procedures are developed and implemented for, (a) cleaning of the home, including, the floors in the resident bedrooms, common areas, staff areas, and (b) addressing all incidents of lingering offensive odours especially on the second floor unit.

The plan will include, at a minimum, the following elements:
- Develop a cleaning schedule for the areas mentioned above, and
- Develop a system to ensure that cleaning routines, systems and procedures are monitored to ensure that all areas of the home are maintained clean, sanitary and without any offensive odours.

Please submit the written plan for achieving compliance for inspection #2018_759502_0012 to Julienne Ngo Nloga, LTC Homes Inspector, MOHLTC, by email to: TorontoSAO.generalemail@ontario.ca by October 19, 2018. Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Review of a complaint received by the Ministry of Health and Long-Term care (MOHLTC) on an identified date indicated that the complainant expressed concern related to uncleanliness of the home.

On an identified date, during the Resident Quality Inspection (RQI), the inspector observed the following areas in the home which were unclean:

1. On an identified floor in the common areas, the inspector observed light brownish and pinkish red stains on the floor inside the dining room, outside the elevator door and around the outside areas of the nursing station.

The unclean state of the above mentioned areas on the floor were confirmed by staff #119, who stated that the stains could be related to the spills of beverage onto the floor by residents. They indicated that the home's process was to call housekeeping staff to clean the floors immediately after spillage occurred. Housekeeping staff were notified immediately after the interview.

2. On identified floors the inspector observed that each floor was in an unclean state with dried and hardened blackish substances collecting in the corners, door jams, around the heating unit pipes, and along the hallway baseboard.

In interviews, housekeeping staff #125 and #126, confirmed the observations noted above. Staff #126 stated that if the floors looked really dirty they would stop and clean it; however, sometimes they might miss cleaning an area because there was so much to get done.

3. An identified resident's room was observed by staff #125 and the inspector. Inside the corners between the wall and the heater were unclean with a dried blackish substance stuck on the floor. The staff verified that the corners on the floor in the resident's room were unclean and needed to be cleaned. The inspector made the same observations in three other identified resident rooms.

During an interview, resident #011 stated that the building was kept unclean, and it was getting worse. They added that a specified floor was especially unclean, that they would prefer to move to another unit if/when the opportunity becomes available.

During an interview, the inspector observed specified floors with the home's Environmental Service Manager (ESM), who confirmed that the areas mentioned above identified during the walk were not properly cleaned, and that a new procedure would be developed and implemented to clean the corners, door jams, around the heating unit pipes, and the baseboards along the hallways. The ESM informed the inspector that the cleanliness of the floors were improved however, they require further treatment and cleaning especially the areas identified above.

Therefore, the home failed to ensure that procedures were developed and implemented for cleaning of the home, including the floors in residents' rooms and common areas. (535)

2. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Review of a complaint submitted to the MOHLTC revealed that the home was very disgusting and had a foul odour.

During the course of the RQI Inspectors #502 and #566 noted lingering odour of urine in the home.

On an identified date and time on a specified unit, Inspector #502 noted a lingering odour of urine.

Staff #123 stated that the lingering odour was a result of resident #016 being incontinent.

Interview with staff #112 stated that they deep clean resident #016's room daily as the resident was incontinent on the floor. They indicated that the urine had penetrated inside the tiles and super absorbent and deodorizer and urine neutralizer are used daily to control the lingering odour.

In an interview staff #111 stated that odour of urine was an ongoing problem as the resident continues to be incontinent on the floor and that the home had a plan to change the entire floor.

The severity of this issue was determined to be a level one as there was minimum risk to the residents. The scope of the issue was a level three as it related to all areas of the home. The home had a level three history as they had previous non-compliance in a similar area with this section of the LTCHA that included a written notification (WN) issued November 14, 2016 (2016_378116_0015). Due to the severity, scope, and history, a compliance order is warranted. (502)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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|---|---|
| Attention Registrar<br>151 Bloor Street West<br>9th Floor<br>Toronto, ON M5S 2T5 | Director<br>c/o Appeals Coordinator<br>Long-Term Care Inspections Branch<br>Ministry of Health and Long-Term Care<br>1075 Bay Street, 11th Floor<br>TORONTO, ON<br>M5S-2B1<br>Fax: 416-327-7603 |

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

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

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

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

| | |
|---|---|
| À l'attention du/de la registrateur(e)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON  M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON  M5S 2B1<br>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 11th day of October, 2018**

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

**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

**Ministére 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 Inspector / Nom de l'inspecteur :** Julienne NgoNloga

**Service Area Office / Bureau régional de services :** Toronto Service Area Office