Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2021	2021_769646_0002	016069-20, 021196-20, 024330-20, 026123-20	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

St. George Care Community
225 St. George Street Toronto ON M5R 2M2

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

IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 22, 25-28, 2021; February 1-5, and 8-11, 2021.

The following Critical Incident System (CIS) intakes were inspected:
- Log #026123-20 (CIS #2594-000001-21) related to falls prevention,
- Log #021196-20 (CIS #2594-000034-20) related to hospitalization resulting in change of condition, and
- Log #024330-20 (CIS #2594-000041-20) related to infection prevention and control.

The following follow-up intake was also inspected:
- Log #016069-20 related to plan of care for nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (ED); Director of Care (DOC); Assistant Directors of Care (ADOCs); the Behavioural Supports Ontario (BSO) Recreation Therapist; Physiotherapist (PT); falls lead; Registered Dietitians (RDs); Director of Dietary Services (DDS); Food Services Supervisor (FSS); Dietary Aides (DAs); Registered Nurses (RNs); Registered Practical Nurses (RPNs); Personal Support Workers (PSWs); Director of Environmental Services (DES); Housekeepers; Corporate Infection Prevention and Control (IPAC) Clinical Partner; Hospital Director of Professional Practice; Hospital Senior Director, Environmental Services, Transportation & Nutrition; Hospital IPAC long-term care (LTC) lead; Hospital Social Worker (SW); scheduling coordinator; residents and advocates.

During the course of the inspection, the inspector toured the home, including shower/tub rooms, residents' rooms and residents' washrooms, the laundry room, the main kitchen; made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews, and reviewed maintenance audits, contractor work orders and reports, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_817652_0005	646

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure the heating, ventilation and air conditioning systems were cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Concerns were raised regarding the state of the resident spa/shower rooms, and the condition of the heating and ventilation systems in the home. The home had a contract in place for heating, ventilation and air conditioning (HVAC) service including regular preventative maintenance quarterly, annually and seasonally. The home had a preventative program in place for cleaning and maintenance of the HVAC system. Audit reports of the home's HVAC cleaning and preventative maintenance program did not identify completion of tasks or if issues were identified or corrected. A Work Order from the home's contracted HVAC service did not indicate what preventative maintenance was completed.

Assessments of the HVAC system by another contractor showed the roof top air handling unit (AHU) was recirculating indoor air and growth of identified substances were identified in the AHU. The fresh air dampers were found to be non-operational and the AHU was supplying resident home areas with recirculated air. The AHU servicing the basement level of the home was found to be powered off with recirculated air being supplied. The ceiling in the basement showed humidity damage and required repairs. Exhaust air systems were reviewed by the contractor which found poor airflow and dirty

air ducts contributing to growth of identified substances in the home's spa/shower rooms.

The Director of Environmental Services (DES) indicated the most recent preventative maintenance was completed about four months prior to the time of the inspection. Documentation of service provided did not include details of additional preventative maintenance or mention of the AHUs in the home. The DES indicated there was a lack of information on the work orders, and they were responsible for overseeing and auditing the maintenance of the HVAC systems in the home. The interim Executive Director (ED) stated the HVAC system in the home was not in a good state of repair, and the procedures developed and implemented were inadequate.

The health of residents and staff members were put at risk when the HVAC system in the home was not in a good state of repair, specifically during a time when the home was experiencing a respiratory outbreak.

[Sources: the Home's Preventative Maintenance Monthly Administration Report audits, Corporate Master Agreement between licensee and contractor (related to HVAC Preventative Maintenance services), Contractor's work orders, Contractor's Investigation of identified substances Growth Report of the home; Contractor's Mechanical Condition and Indoor Air Quality Assessment; Observation of residents' spa/shower rooms; interviews the hospital's Director of Professional Practice, the Director of Environmental Services (DES), the interim Executive Director (ED), and other staff.] [s. 90. (2) (c)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

A. During a tour of the home, observations of residents' spa/shower rooms showed chipped floor and wall tiles, and black substance on the wall tiles and grout. A contractor was hired to conduct a review of the conditions in the spa/shower rooms in the home. The contractor noted issues in all spa/shower rooms in the home, including surface growth of identified substances on grout, wall and floor tiles, broken and damaged tiles and water damage to drywall and painted surfaces. Major remediation work was recommended to the home by the contractor to restore each spa/shower room in the home to a state of good repair.

There were risks to residents when they were using spa/shower rooms that were not well maintained, with broken tiles and growth of identified substances. The residents were not

using the spa/shower rooms at the time of the inspection due to the respiratory outbreak and the identified substances in the spa/shower rooms, and residents would not be able to use the spa/shower rooms until the renovation and remediation work was completed.

B. Observations were made in several resident rooms throughout the home. The washrooms in six residents' rooms were identified with concerns, including: Laminate flooring in disrepair; black substance noted where the flooring was pulling up; uneven surface was observed on the flooring in front of the resident's sink; and cracked and uneven surface on the floor which presented a tripping hazard. Review of the maintenance records over the past year for the six rooms above did not show any reports related to washroom flooring issues.

The DES indicated it was the responsibility of the maintenance department to ensure resident rooms are maintained in a safe condition and in a state of good repair. Monthly resident room audits were to be completed with any areas of concern documented for maintenance requests, and many tasks had been missed. The DES was responsible for the operation of the maintenance department, and had not completed appropriate audits of required maintenance work. There was risk to residents as their washrooms were not maintained in a state of good repair, and in some cases a tripping hazard was identified.

[Sources: Home's Preventative Maintenance Monthly Administration Report audits, MaintenanceCare reports for identified residents' spa/shower rooms and rooms, Contractor's Investigation of identified substances Growth Report of the home; Observation of above rooms and residents' spa/shower rooms; interviews with PSW, the hospital's Director of Professional Practice, the DES, the interim ED, and other staff.] [s. 90. (2) (d)]

Additional Required Actions:

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

WN #2: 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).

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, (a) in the assessment of one resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The resident was found in distress after a meal, and was transferred to hospital. The resident was at risk of choking related to swallowing difficulties. The resident was to be provided a modified texture diet with thickened fluids, and provided feeding assistance. Staff were to position the resident upright during and after eating.

Training materials for staff indicated the resident should be positioned with their head of bed at a 90 degree angle, and if the resident could not tolerate sitting at that angle, to position the resident at a 75 to 90 degree angle to minimize risk of choking or aspiration. After the meal is completed, the resident’s head of bed should not be lowered below a 60 degree angle.

On the day of the incident, the resident was found to be improperly positioned during and after the meal. The staff had reported a bed function issue for the roommate’s bed prior, but there was no documentation regarding the resident’s bed. A PSW stated they were aware the resident was to be seated upright, but the resident’s bed was not able to be elevated to a 90 degree angle, and could not maintain good position for the resident. Staff reported issues about the resident’s bed had been reported to maintenance in the past. Registered staff were expected to monitor residents during meals, but the RPN indicated they had not observed the resident during the meal on the day of the incident.

The Director of Care (DOC) stated that if the resident was eating in bed, they should be positioned at a 75 to 90 degree angle. The staff should have reported any issues with the resident's bed to maintenance. The registered staff were also expected to monitor residents for appropriate positioning during and after meals. None of these were done for the resident at the time of the incident.

[Sources: CIS report, menu on the day of the incident, Maintenance Care records, resident's progress notes, home's investigation notes, risk management notes, Staff Education "Sienna Dining Experience Eating Assistance for Residents w/ Dementia"; interviews with PSWs, RPN, RD, Director of Dietary Services (DDS), Director of Care (DOC), and other staff] [s. 6. (4)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other, (a) in the assessment of one resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted related to the fall of one resident, which resulted in transfer to hospital.

A. A resident had an unwitnessed fall and was found on the floor by a PSW. The resident was at risk for falls, and staff were to ensure the resident's assistive mobility device was within reach and to supervise them for safety. The resident used a second assistive mobility device for locomotion, but used the first assistive mobility device for transferring themselves per their care plan. Assessment by the physiotherapist (PT) showed the resident needed supervision and set up assistance for transferring, and use of a the first assistive mobility device for ambulation. An RPN indicated that the resident would not allow staff to assist with transferring prior to their fall and used the first assistive mobility device for transferring.

The PT indicated that they had not assessed the resident for safety with transferring using the first assistive mobility device, and was unsure why the resident's care plan indicated to use it for transfer. The ADOC indicated staff had been providing the resident with the first assistive mobility device for transferring, despite this method not being assessed for safety. The resident's safety was put at risk by using a transfer aid that they

had not been assessed for use and staff did not collaborate in their assessment of the resident.

B. A resident was to receive scheduled monitoring for safety due to a history of responsive behaviours which put them at risk for fall and injury. The PSW working with the resident on the day of the incident was not aware that this intervention was used for falls prevention, and had not checked on the resident as they were not familiar with the resident's care. Documentation of the monitoring was incomplete on the shift in which the resident fell. The RPN indicated that the resident would transfer without assistance, and the monitoring schedule was effective in ensuring the resident's safety. The BSO lead indicated they were not consulted on interventions related to the behaviour of self-transferring and did not provide interventions to manage this risk. The ADOC stated the most effective falls prevention intervention for the resident was close monitoring, which was not provided to the resident at the time of the incident. The ADOC stated there was a lack of collaboration in developing and providing the resident's falls plan of care. The resident was at increased risk for fall and injury as there was a lack of collaboration in implementing the resident's plan of care for falls prevention.

[Sources: Critical Incident System (CIS) report, Home's investigation notes from the incident, Documentation Survey Report V2, Risk Management Assessment, progress notes, MDS; interviews with PSW, RPN, PT, BSO lead, ADOC, and other staff] [s. 6. (4)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of one resident collaborated with each other in the development and implementation of their nutrition plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The licensee was issued a Compliance Order (CO) #001 from inspection #2020_817652_0005 / 008659-20 regarding s. 6. (7).

The resident was at risk for choking, and was to receive a modified texture diet. The inspector observed meals plated on the unit, with stickers on each tray indicating the name of the resident with their diet, diet texture, and fluid consistency. The resident's tray showed a label for regular texture diet instead of modified texture, and pieces of regular texture food was seen on the edge of the plate for the resident. The PSW stated that the resident should receive a modified texture diet, and the sticker listed the incorrect texture. The diet list showed the resident was to receive a modified texture diet. The Dietary Aide (DA) stated they should have followed the diet list, and should have reported to the

Director of Dietary Services (DDS) the error in the printed sticker. The DDS stated the DAs should be plating the meals based on the diet list and not the meal tray labels. The label had the incorrect diet texture for the resident. The lack of collaboration in implementing the resident's plan of care, put the resident at risk for choking if provided the incorrect diet texture.

[Sources: Resident's care plan , Residents at High Risk for Choking List, Unit's diet list, home's mealtime audits; Observation at mealtimes, observation of meal service and delivery; interviews with PSW, Dietary Aides (DA), RPN, RD, Director of Dietary Services (DDS), DOC, interim ED, and other staff] [s. 6. (4) (b)]

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

The resident was at risk for falls. Falls prevention interventions were planned for the resident. The resident had an unwitnessed fall from bed on an identified date, and was not provided one of their falls prevention interventions at the time.

Three days later, staff documented that the falls prevention intervention was not available, and nursing would follow-up with another department to locate them. The resident was observed without their falls prevention intervention later that day. Staff in the next shift were not aware that the resident was not provided their falls prevention intervention, and it was not communicated to them to provide it to the resident once place them on the resident once the item was returned from the other department.

The Assistant Director of Care (ADOC)/falls lead stated that staff were expected to notify the managers who could provide an extra falls prevention intervention for the resident right away. The DOC stated there was a falls kit on each floor with falls prevention interventions which the staff could have used.

The resident was at risk for injuries related to falls when the staff did not collaborate to implement the plan of care for use of the falls prevention intervention.

[Sources: Resident's current plan of care, Risk Management record, Documentation Survey v2, progress notes, observations of the resident, interviews with PSW, Assistant

Director of Care (ADOC), ADOC /falls lead, DOC, and other staff.] [s. 6. (4) (b)]

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 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 :

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.

Staff reported that a resident's bed was not able to be elevated to a 90-degree angle to provide safe positioning when the resident was having meals in bed. MaintenanceCare records for the resident's room showed one of the beds was reported to be functioning poorly. The bed function was never documented as completed by maintenance. Maintenance staff were to complete audits of resident room for needed repairs twice annually. These audits did not show what issues were identified or addressed by maintenance staff.

Inspector's observation of one of the beds in the identified room showed the head of the bed could not be raised to more than a 60-degree angle. The PSW stated this bed should be reported to the maintenance as the head of bed was not elevating and needed repair. The PSW reported that other beds had this issue and they had reported to maintenance in the past. The PSW provided feeding assistance to the resident on the day of their incident stated the resident's bed could only elevate to about 60-degrees.

The DES indicated it was the responsibility of the maintenance department to ensure resident rooms are maintained in a safe condition and in a state of good repair. Monthly resident room audits were to be completed with any areas of concern documented for maintenance requests, and many tasks had been missed. The DES was responsible for the operation of the maintenance department and had not completed appropriate audits of required maintenance work.

The interim ED stated they expected the maintenance staff to ensure the home, furnishing, and equipment were in a good state of repair, and this was not done related to the resident's bed and another bed in the same room.

[Sources: CIS report, the home's Preventative Maintenance Monthly Administration Report audits, MaintenanceCare reports, room observation, interviews with PSWs, the Director of Environmental Services (DES), interim ED, and other staff.]

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2020_817652_0005.

The licensee was required to prepare, submit and implement a plan to ensure that residents who have been identified as high risk for choking were closely monitored and supervised. The licensee was required to implement a process to ensure these residents were monitored and supervised during meals.

One of the home's corrective actions to develop and implement a process to ensure that all residents within the home identified as high risk for choking would receive monitoring and supervision during meals, was to create a process that communicated residents that are at high risk for choking to the interdisciplinary healthcare team directly involved in supporting the resident's needs.

The RDs created a Residents at High Risk of Choking list for registered staff communicate which residents are at high risk and required monitoring and supervision during meals. The list was to be placed at the nursing stations and available for registered staff and PSWs to refer to. On one out of the three units reviewed, the list was not found at the nursing station. An RPN who worked on the home area stated the list may have fallen off and was unable to find a list for the staff on the unit. The DOC stated the Residents at High Risk of Choking list should have been posted at the nursing station on each unit as a resource to communicate to the team about residents at high risk for choking, and it was not for one unit.

[Sources: Compliance Order (CO) #001 from inspection #2020_817652_0005, home's compliance plan, mealtime audits; Observation of Residents at High Risk for Choking List for three unit, observation of nursing stations on three units; interviews with RPN, RDs, DOC, and other staff]

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 compliance with all the conditions contained in the past-due order made under the Act, to be implemented voluntarily.

WN #5: 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 :

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program required under subsection 86 (1) of the Act.

This inspection was initiated related to a CIS report related to a COVID outbreak declared in the home.

A PSW was observed entering the dining room without performing hand hygiene. The PSW physically handled food items which were to be served to residents. The DDS stated the PSW should not have touched the food with their hands, and this was not in accordance with the home's IPAC program. The home's Corporate IPAC Clinical Partner stated only the DA's can portion out the food as only they are trained to do so, and this reduces contamination of the food for residents.

This inspection was conducted while there was a COVID-19 outbreak in the home. There was risk to residents when the staff did not participate in the IPAC program in the home during meal service and delivery.

[Sources: CIS report; Observations during resident mealtimes; Interviews with PSW, DA, DDS, IPAC Clinical Partner, and other staff.]

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 all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 30th day of March, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IVY LAM (646)
Inspection No. / No de l'inspection :	2021_769646_0002
Log No. / No de registre :	016069-20, 021196-20, 024330-20, 026123-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 25, 2021
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	St. George Care Community 225 St. George Street, Toronto, ON, M5R-2M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy de Vera

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 90 (2).

Specifically, the licensee must:
1) In collaboration with the Director of Environmental Services (DES), Executive Director (ED) and/or Associate ED, review the home's heating, ventilation and air conditioning (HVAC) Preventative Maintenance Services audit to confirm that the HVAC system is inspected twice per year at a minimum by a certified individual so that the HVAC system is clean and in a good state or repair, including who is responsible to oversee each component of the audit.

2) Communicate with the contractor when quarterly and semi-annual contracted services (including but not limited to major and seasonal inspections) are to be completed. Contractor work orders need to include details about which components were inspected and what adjustments were made.

3) Audit a) the home's air handling units and exhaust systems for all home areas so that they are operating, clean, and in a good state of repair, and b) The maintenance work completed by contractors include documentation of the date of service, detail of work completed, and recommendations to the home.

4) In collaboration with the DES, the ED and/or the Associate ED, develop a monthly audit related to the cleanliness and state of repair of residents' washrooms and spa/shower rooms, so that they are maintained and kept free of corrosion and cracks. The audit is to be communicated to all maintenance staff and completed as scheduled.

5) All spa/shower rooms and the six identified residents' washrooms are to be audited and kept in a good state of repair.

6) Have the nursing department aware of and use the home's maintenance reporting system to report when residents' washrooms and shower rooms are not in a good state of repair. Ensure maintenance staff review and complete the reported tasks and document appropriately in the home's maintenance reporting system.

7) Hold monthly meetings between the DES, ED and/or Associate ED, for three months following the receipt of this order, to review completed audits and other maintenance work to determine what changes need to be made.

8) For items 1) to 7), keep a record of meetings (including dates, names of person in attendance, content discussed), communications, audits (including dates, name and room number of residents, names of person completing the audit, issues identified), and follow-ups (including dates, person completing follow-up, corrections made).

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure the heating, ventilation and air conditioning systems were cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Concerns were raised regarding the state of the resident spa/shower rooms, and the condition of the heating and ventilation systems in the home. The home had a contract in place for heating, ventilation and air conditioning (HVAC) service including regular preventative maintenance quarterly, annually and seasonally. The home had a preventative program in place for cleaning and maintenance of the HVAC system. Audit reports of the home's HVAC cleaning and preventative maintenance program did not identify completion of tasks or if issues were identified or corrected. A Work Order from the home's contracted HVAC service did not indicate what preventative maintenance was completed.

Assessments of the HVAC system by another contractor showed the roof top air handling unit (AHU) was recirculating indoor air and growth of identified substances were identified in the AHU. The fresh air dampers were found to be non-operational and the AHU was supplying resident home areas with recirculated air. The AHU servicing the basement level of the home was found to be powered off with recirculated air being supplied. The ceiling in the basement showed humidity damage and required repairs. Exhaust air systems were reviewed by the contractor which found poor airflow and dirty air ducts contributing to growth of identified substances in the home's spa/shower rooms.

The Director of Environmental Services (DES) indicated the most recent preventative maintenance was completed about four months prior to the time of the inspection. Documentation of service provided did not include details of additional preventative maintenance or mention of the AHUs in the home. The

DES indicated there was a lack of information on the work orders, and they were responsible for overseeing and auditing the maintenance of the HVAC systems in the home. The interim Executive Director (ED) stated the HVAC system in the home was not in a good state of repair, and the procedures developed and implemented were inadequate.

The health of residents and staff members were put at risk when the HVAC system in the home was not in a good state of repair, specifically during a time when the home was experiencing a respiratory outbreak.

[Sources: the Home's Preventative Maintenance Monthly Administration Report audits, Corporate Master Agreement between licensee and contractor (related to HVAC Preventative Maintenance services), Contractor's work orders, Contractor's Investigation of identified substances Growth Report of the home; Contractor's Mechanical Condition and Indoor Air Quality Assessment; Observation of residents' spa/shower rooms; interviews the hospital's Director of Professional Practice, the Director of Environmental Services (DES), the interim Executive Director (ED), and other staff.] (646)

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

A. During a tour of the home, observations of residents' spa/shower rooms showed chipped floor and wall tiles, and black substance on the wall tiles and grout. A contractor was hired to conduct a review of the conditions in the spa/shower rooms in the home. The contractor noted issues in all spa/shower rooms in the home, including surface growth of identified substances on grout, wall and floor tiles, broken and damaged tiles and water damage to drywall and painted surfaces. Major remediation work was recommended to the home by the contractor to restore each spa/shower room in the home to a state of good repair.

There were risks to residents when they were using spa/shower rooms that were not well maintained, with broken tiles and growth of identified substances. The residents were not using the spa/shower rooms at the time of the inspection due

to the respiratory outbreak and the identified substances in the spa/shower rooms, and residents would not be able to use the spa/shower rooms until the renovation and remediation work was completed.

B. Observations were made in several resident rooms throughout the home. The washrooms in six residents' rooms were identified with concerns, including: Laminate flooring in disrepair; black substance noted where the flooring was pulling up; uneven surface was observed on the flooring in front of the resident's sink; and cracked and uneven surface on the floor which presented a tripping hazard. Review of the maintenance records over the past year for the six rooms above did not show any reports related to washroom flooring issues.

The DES indicated it was the responsibility of the maintenance department to ensure resident rooms are maintained in a safe condition and in a state of good repair. Monthly resident room audits were to be completed with any areas of concern documented for maintenance requests, and many tasks had been missed. The DES was responsible for the operation of the maintenance department, and had not completed appropriate audits of required maintenance work. There was risk to residents as their washrooms were not maintained in a state of good repair, and in some cases a tripping hazard was identified.

[Sources: Home's Preventative Maintenance Monthly Administration Report audits, MaintenanceCare reports for identified residents' spa/shower rooms and rooms, Contractor's Investigation of identified substances Growth Report of the home; Observation of above rooms and residents' spa/shower rooms; interviews with PSW, the hospital's Director of Professional Practice, the DES, the interim ED, and other staff.]

An order was made by taking the following factors into account:
Severity: There was minimal risk to residents when procedures were not implemented to ensure: A. The HVAC system was not in a good state of repair, and B. All plumbing fixtures and washroom fixtures and accessories were not maintained and kept free of corrosion and cracks.
Scope: This non-compliance was widespread, as the HVAC system impacted the hallway and common areas of all home areas; three home areas' spa/shower rooms and residents' washrooms were observed to be poorly

maintained.
Compliance History: In the past 36 months, two other COs were issued to different sections of the legislation, all of which have been complied. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 18, 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 : 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. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.(4).

Specifically, the licensee must:
1) Review the electronic care plan, diet list and diet labels for resident #001 to verify the resident's diet and diet texture are the same. Provide resident #001 with the correct diet and diet texture as specified in their care plan.

2) Audit all residents' beds in the home to check that the beds can be elevated to a 90-degree angle. Report any beds identified with issues to maintenance to be fixed and/or replaced using the maintenance reporting system.

3) Hold monthly meetings between the DES, ED and/or Associate ED, for three months following the receipt of this order, to review the maintenance reporting system documentation so that bed issues are identified, responded to and corrected in a timely manner.

4) Identify residents who regularly have meals in bed. In collaboration with the registered dietitian(s) and nursing staff, determine safe positioning for identified residents. Have PSWs and PCAs demonstrate they can achieve the angle while the resident is in the bed. Conduct mealtime positioning audits at each meal for the identified residents. Have registered staff monitor residents during mealtimes.

5) Provide resident #004 and all residents at risk for falls with falls risk interventions as per their care plans.

6) Identify residents who ambulate and/or transfer with both the two types of identified assistive mobility devices. Collaborate with the physiotherapist to assess and determine if both are appropriate for the identified residents, and include the interventions in their care plans.

7) Identify residents whose falls risks are related to refusal of staff assistance. Collaborate with the Behavioural Supports Ontario (BSO) lead to assess, develop and implement interventions to minimize residents' risk for falls for the identified residents and include the interventions in their care plans.

8) For items 1) to 7): a) For audits, keep a record including dates, name and room number of residents, names of person completing the audit, meal audited, issues identified, corrections made; b) For meetings, keep a record of meetings (including dates, names of person in attendance, name and room number of residents whose care plans were reviewed and revised, content discussed, corrections made).

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of one resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The resident was found in distress after a meal, and was transferred to hospital. The resident was at risk of choking related to swallowing difficulties. The resident was to be provided a modified texture diet with thickened fluids, and provided feeding assistance. Staff were to position the resident upright during and after eating.

Training materials for staff indicated the resident should be positioned with their head of bed at a 90 degree angle, and if the resident could not tolerate sitting at

that angle, to position the resident at a 75 to 90 degree angle to minimize risk of choking or aspiration. After the meal is completed, the resident's head of bed should not be lowered below a 60 degree angle.

On the day of the incident, the resident was found to be improperly positioned during and after the meal. The staff had reported a bed function issue for the roommate's bed prior, but there was no documentation regarding the resident's bed. A PSW stated they were aware the resident was to be seated upright, but the resident's bed was not able to be elevated to a 90 degree angle, and could not maintain good position for the resident. Staff reported issues about the resident's bed had been reported to maintenance in the past. Registered staff were expected to monitor residents during meals, but the RPN indicated they had not observed the resident during the meal on the day of the incident.

The Director of Care (DOC) stated that if the resident was eating in bed, they should be positioned at a 75 to 90 degree angle. The staff should have reported any issues with the resident's bed to maintenance. The registered staff were also expected to monitor residents for appropriate positioning during and after meals. None of these were done for the resident at the time of the incident.

[Sources: CIS report, menu on the day of the incident, Maintenance Care records, resident's progress notes, home's investigation notes, risk management notes, Staff Education "Sienna Dining Experience Eating Assistance for Residents w/ Dementia"; interviews with PSWs, RPN, RD, Director of Dietary Services (DDS), Director of Care (DOC), and other staff] (646)

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other, (a) in the assessment of one resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted related to the fall of one resident, which resulted in transfer to hospital.

A. A resident had an unwitnessed fall and was found on the floor by a PSW. The

resident was at risk for falls, and staff were to ensure the resident's assistive mobility device was within reach and to supervise them for safety. The resident used a second assistive mobility device for locomotion, but used the first assistive mobility device for transferring themselves per their care plan. Assessment by the physiotherapist (PT) showed the resident needed supervision and set up assistance for transferring, and use of a the first assistive mobility device for ambulation. An RPN indicated that the resident would not allow staff to assist with transferring prior to their fall and used the first assistive mobility device for transferring.

The PT indicated that they had not assessed the resident for safety with transferring using the first assistive mobility device, and was unsure why the resident's care plan indicated to use it for transfer. The ADOC indicated staff had been providing the resident with the first assistive mobility device for transferring, despite this method not being assessed for safety. The resident's safety was put at risk by using a transfer aid that they had not been assessed for use and staff did not collaborate in their assessment of the resident.

B. A resident was to receive scheduled monitoring for safety due to a history of responsive behaviours which put them at risk for fall and injury. The PSW working with the resident on the day of the incident was not aware that this intervention was used for falls prevention, and had not checked on the resident as they were not familiar with the resident's care. Documentation of the monitoring was incomplete on the shift in which the resident fell. The RPN indicated that the resident would transfer without assistance, and the monitoring schedule was effective in ensuring the resident's safety. The BSO lead indicated they were not consulted on interventions related to the behaviour of self-transferring and did not provide interventions to manage this risk. The ADOC stated the most effective falls prevention intervention for the resident was close monitoring, which was not provided to the resident at the time of the incident. The ADOC stated there was a lack of collaboration in developing and providing the resident's falls plan of care. The resident was at increased risk for fall and injury as there was a lack of collaboration in implementing the resident's plan of care for falls prevention.

[Sources: Critical Incident System (CIS) report, Home's investigation notes from the incident, Documentation Survey Report V2, Risk Management Assessment,

progress notes, MDS; interviews with PSW, RPN, PT, BSO lead, ADOC, and other staff] (646)

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of one resident collaborated with each other in the development and implementation of their nutrition plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The licensee was issued a Compliance Order (CO) #001 from inspection #2020_817652_0005 / 008659-20 regarding s. 6. (7).

The resident was at risk for choking, and was to receive a modified texture diet. The inspector observed meals plated on the unit, with stickers on each tray indicating the name of the resident with their diet, diet texture, and fluid consistency. The resident's tray showed a label for regular texture diet instead of modified texture, and pieces of regular texture food was seen on the edge of the plate for the resident. The PSW stated that the resident should receive a modified texture diet, and the sticker listed the incorrect texture. The diet list showed the resident was to receive a modified texture diet. The Dietary Aide (DA) stated they should have followed the diet list, and should have reported to the Director of Dietary Services (DDS) the error in the printed sticker. The DDS stated the DAs should be plating the meals based on the diet list and not the meal tray labels. The label had the incorrect diet texture for the resident. The lack of collaboration in implementing the resident's plan of care, put the resident at risk for choking if provided the incorrect diet texture.

[Sources: Resident's care plan , Residents at High Risk for Choking List, Unit's diet list, home's mealtime audits; Observation at mealtimes, observation of meal service and delivery; interviews with PSW, Dietary Aides (DA), RPN, RD, Director of Dietary Services (DDS), DOC, interim ED, and other staff] (646)

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

The resident was at risk for falls. Falls prevention interventions were planned for the resident. The resident had an unwitnessed fall from bed on an identified date, and was not provided one of their falls prevention interventions at the time.

Three days later, staff documented that the falls prevention intervention was not available, and nursing would follow-up with another department to locate them. The resident was observed without their falls prevention intervention later that day. Staff in the next shift were not aware that the resident was not provided their falls prevention intervention, and it was not communicated to them to provide it to the resident once place them on the resident once the item was returned from the other department.

The Assistant Director of Care (ADOC)/falls lead stated that staff were expected to notify the managers who could provide an extra falls prevention intervention for the resident right away. The DOC stated there was a falls kit on each floor with falls prevention interventions which the staff could have used.

The resident was at risk for injuries related to falls when the staff did not collaborate to implement the plan of care for use of the falls prevention intervention.

[Sources: Resident's current plan of care, Risk Management record, Documentation Survey v2, progress notes, observations of the resident, interviews with PSW, Assistant Director of Care (ADOC), ADOC /falls lead, DOC, and other staff.]

An order was made by taking the following factors into account:
Severity: There was actual risk to one resident when staff did not collaborate to provide proper positioning when eating as per their care plan. There was minimal risk when staff did not collaborate to develop and implement plans of care for four residents at risk for falls.
Scope: This non-compliance was a pattern, as out of the nine residents reviewed, five residents were affected. Compliance History: In the past 36 months, the licensee was found to be noncompliant with LTCHA s. 6.(4), and a voluntary plan of correction (VPC) was issued. (646)

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 : Jun 18, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 25th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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