Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 20, 2015	2015_346133_0005	O-001534-15	Other

Licensee/Titulaire de permis

1663432 ONTARIO LTD.
2212 GLADWIN CRESCENT UNIT A-9, SUITE 200 OTTAWA ON K1B 5N1

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): February 24th - 27th, 2015.

This inspection was conducted concurrently with complaint inspection #2015-198117-0007, log # O-001456-14, by Long Term Care Home Inspector # 117. Some of the findings, as noted within this report, are related to that complaint.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the office manager, the maintenance worker, housekeepers, nursing staff, and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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 comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (a) in that the licensee has failed to ensure that the home is kept clean and sanitary.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Written Notification was issued.

a) Inspector #133 conducted an inspection at the home on February 24th – 27th, 2015. The following widespread non-compliance relating to cleanliness of walls and lower doors was observed throughout the inspection.

West dining room – The walls were very heavily soiled with dried food matter, most pronounced in the area around the front area of the room, but notable throughout. As well, upon entry to the dining room, along the right wall, mid-way to the serving station, areas of the wall were dirty with dried sputum, as identified by a housekeeper, staff # S105. The housekeeper, and a dietary staff person in the area at the time of the conversation, explained that there is a resident who eats at the table closest to that area and who regularly spits on the walls and floor.

Bedroom A – In the bathroom, the wall across from the toilet, and the floor underneath, was very heavily soiled with thick accumulations of dried sputum. The outer bathroom door and surrounding walls were also very dirty with areas of dried sputum. The Inspector reported this to the Administrator at the end of the inspection day, on February 24th, 2015, and the bathroom and bedroom were thoroughly cleaned on February 26th, 2015.

Private Lounge – Lower walls throughout were dirty with dried matter and scuff marks. This was most pronounced next to the doorway, but notable throughout. The center pillar was similarly soiled.

Bedroom #115 – The lower bathroom wall, across from the toilet, was dirty with dried brown matter (under the towel bar and around the garbage can).

Bedroom #137 – The lower bathroom wall, to the left of the toilet, was dirty with spots of dried dark matter.

Bedroom #129 – The lower bathroom wall, to the left of the sink, was dirty with spots of dried dark brown matter.

Bedroom #127 – The lower bathroom walls, throughout, were dirty with spots of dried matter of various colours.

Bedroom #131 – The lower bathroom wall was dirty with spots of dried matter and scuff marks.

Bedroom #125 – The lower bathroom walls, throughout, were dirty with spots of dried brown matter.

Bedroom #135 – The lower bathroom walls, throughout, were dirty with spots of dried matter, most pronounced around the toilet.

Bedroom #145 – The lower bathroom walls were dirty with spots of dried dark matter.

Public bathroom within main entrance area – The lower walls were dirty with spots of dried brown matter throughout, scuff marks, and areas of what appeared to be dried toilet tissue paper or other such similar material.

It is to be noted that observations pertaining to the cleanliness of the public bathroom are related to complaint inspection # 2015-198117-0007 , log is # O-001456-14, which was conducted by Long Term Care Home Inspector # 117, concurrent with Inspector #133's inspection.

West staff bathroom – The lower wall next to the toilet was dirty with spots of dried dark coloured matter.

Bedroom #103 – Lower walls throughout the bedroom were dirty with dried matter (i.e. next to the bed, around the fridge, to the left of the bathroom door)

Main entrance lobby area and unit hallways – Lower walls throughout are dirty with spots of dried matter of various colour (i.e. outside of public bathroom, outside of janitors room and kitchen entrance, outside of the private lounge, to the left of the bird cage, outside of south dining room, outside of the south nurses' office, outside of room #146, throughout the south and west hallways, in the west activity room, south shower room, south activity room)

b. Exhaust vents – Throughout the inspection, Inspector #133 observed that exhaust vents in the following identified resident bathrooms were dirty with a heavy accumulation of dust: #140, #119, #121/123, #136, #130, #112, #128, #126, #118. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Voluntary Plan of Correction was issued, and an immediate Compliance Order was served on the licensee.

a) Inspector #133 conducted an inspection at the home on February 24th – 27th, 2015. Widespread non-compliance relating to the overall maintenance of the home was observed over the course of the inspection.

b) Flooring in identified residents' bathrooms, the South tub room, and the bathroom that serves the south tub and shower room:

i) Vinyl sheet flooring is in place in the identified areas. The flooring has shrunk and there is a loss of adhesion between the flooring and the concrete beneath in the majority of the areas. Along at least two of the 3 walls, in the majority of the areas, the flooring edges have curled, and pulled away from the baseboards, creating a gap ranging from approximately .5 inches to 1.5 inches. In a few cases, while the flooring has shrunk and pulled away from the baseboards, the edges remain flat. Accumulated dirt, debris, and in one case, pests, were observed within the gaps and beneath the loose flooring. For example, in the South tub room, along the gap and beneath the flooring, in the back left corner, the Inspector observed a heavy accumulation of sand and debris, and a number of small ants.

This flooring problem was observed in the following resident bedrooms: 122, 116, 114, 107, 137, 129, 125, 133, 135, 137, 147, 104, 128, 145.

ii) The vinyl sheet flooring in place in resident bathrooms is light brown in colour. In identified areas, the flooring was extensively discoloured with blackened areas and in some cases, scuff marks.

This flooring problem was observed in the following resident bedrooms: 118, 131, 133, 129, 145, 124

c) Lower wall surfaces in common areas:

Lower wall surfaces throughout the home were in a poor repair at the time of the inspection. Lower wall surfaces were gouged, pitted, chipped and peeling, and scuffed. Holes in walls were also observed in some areas, such as in the west dining room, the public bathroom, and in resident bathrooms #116 and #107. Also in the public bathroom, the baseboard was not adhered to the wall and was leaning outwards, behind and beside the toilet.

Identified areas of concern are as follows: Public bathroom, the South and West dining rooms, South tub and shower rooms, the main entrance area (i.e. around the kitchen and janitor doors, lower door leading into the private lounge), to varying degrees, throughout the South and the West unit hallways, West activity room, South activity room, bathroom #133 (damage patched but not finished, baseboard not adhered to wall).

It is to be noted that observations pertaining to the state of repair of the public bathroom are related to complaint inspection # 2015-198117-0007 , log is # O-001456-14, which was conducted by Long Term Care Home Inspector # 117, concurrent with Inspector #133's inspection.

d) Bathroom exhaust:

Throughout Inspector #133's initial tour of the South hallway, it was generally noted that the exhaust system in resident bathrooms, throughout, was unusually loud. When beginning observations in the West hallway, in bedroom #101, the Inspector could not detect any audible exhaust. Standing on a chair, the Inspector held a small piece of single ply tissue up to the vent, and found that there was no suction, causing the tissue to fall to the floor. This was done with the light on and off, as it was not clear if the exhaust system is dependent on the light being on or not. This was reported to a maintenance worker at the home, staff # S106, who later confirmed that there was no bathroom exhaust in bedroom #101, because the exhaust fan, within the ceiling, had been unplugged. He explained that the bathroom exhaust in resident's bathrooms is so loud because the fans are old, and the blades dulled. He explained that by replacing an old fan with a new one in a resident's bathroom, the exhaust system is rendered almost

silent. This was the case in bedroom #105, where the Inspector had initially thought that the bathroom exhaust system was not functional, but had not tested for suction using a single ply tissue. The maintenance worker had followed up, and pointed out that there was a newer exhaust fan in this bathroom. Following discussion with the Inspector, the maintenance worker was going to check for exhaust in the following bedrooms that remained in question: #119, #135, #115, #147, #142, #100, #102, #108.

On February 25th, 2015, in an identified bedroom, resident #004 explained to the Inspector that they had found their bathroom exhaust was too loud, and that they had requested that the maintenance worker unplug it, on February 24th, 2015, as it was disturbing to them, particularly when resting. The resident explained that regardless of the position of the light switch, the exhaust system in their bathroom comes on at various noted times, such as between 7:12 am – 8:20 am, 11:10am – 12:10pm, and 4:17pm – 7:15pm. The resident went on to explain that the maintenance worker had replaced their bathroom exhaust fan with a new one, on February 25th, 2015. The resident remarked that the exhaust was now quiet, and was pleased with the intervention.

e) Handrails throughout the home:

The handrails in the unit hallways are wooden, and little to no surface finish remains, thereby exposing the porous wood beneath. These absorbent surfaces cannot be cleaned and disinfected.

f) It is noted that the maintenance worker in place at the time of the inspection, staff # S106, explained to the Inspector that he is currently implementing a comprehensive maintenance program at the home. This staff person explained to the Inspector that he has been brought in to help the home in the absence of the home's Environmental Supervisor, who has been away since mid to late December 2014.

g) The above observations made over the course of the 4 day inspection represent a widespread failure of the home's existing maintenance program, presenting a potential risk to the comfort, safety, and well being of the residents. [s. 15. (2) (c)]

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 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,
(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; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (i) in that the licensee has not developed and implemented procedures to ensure that 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.

2. On February 24th, 2015, in the West tub room, Inspector #133 measured the temperature of the hot water at the bathtub. After running the water for 5 minutes, the Inspector measured the water temperature at 1 minute intervals, between 3:09pm and 3:16pm. The temperature dial was in its highest position. The temperatures measured were as follows: 33 C, 40.3 C, 39 C, 35.5 C, 37.7 C, 40 C, 38 C, 37.3 C.

3. While in the West tub room, following the water temperature measurement process described above, a Personal Support Worker (PSW), staff #S100, told the Inspector that it is not unusual that the water at this tub goes cold while bathing residents. Another PSW, staff #S101, came along at the same time, and told the Inspector that there are times they get residents ready for a bath, get them up into the tub lift, but then there is no more hot water so they have to take them out of the lift and dress them again. Later that afternoon, in the West tub room, another PSW, staff #S102, told the Inspector that it's not unusual that the water at the bathtub goes from hot to cold while bathing a resident, and that the residents do not like it.

4. On February 24th, 2015, in the South tub room, a PSW, staff #S103, told the Inspector that the water temperature in the tub is not always stable. They said that they can have a resident in the tub, and while giving a tub shower, the water can get hot, then without doing anything at all, the water can get cold.

5. On February 25th, 2015, at 10:13am, the Inspector entered the West tub room and met a PSW, staff #S104 , who was running the tap in attempt to get warm water. The PSW (#S104) indicated that the water had been running for several minutes. It was noted that over two minutes, the hot water temperature went from 28 C down to 22 C. Beginning at 10:16am, the Inspector began noting the temperature at one minute intervals. The temperature measurements were as follows: 25.8 C, 23.1 C, 26 C, 31.3 C, 31.2 C, 33.5C, 35.5 C, 35.5 C, 35.7 C. The PSW (#S104) felt that the temperature of the hot water, at 35.7 C, was sufficient to bathe the resident who was waiting for a bath, resident #002. The Inspector left the West tub room, and the PSW proceeded with the bath. The Inspector returned to the West tub room at 11:07am, and spoke with the PSW again, to enquire about resident #002's bath. The PSW (#S104) clarified that they do not give residents a tub bath, only a tub shower, because due to the ongoing water temperature fluctuations, when the tub is left to fill up over a period of time, they often find the water is too cold to bathe a resident, and this wastes a full tub of water. The PSW (#S104) proceeded to explained that if they are using the shower wand, at least they can pull it away from the resident when it gets cold. Relating to resident #002, the PSW (#S104) explained that there had been sufficient supply of warm water for the resident's tub shower. The PSW indicated that they had showered another resident, #003, in the tub, after resident #002, and that the water had gone cold during the process, causing resident #003 discomfort and to yell out at them that it was too cold.

6. On February 25, 2015, at 3:30pm, Inspector #133, the Administrator and the Office Manager went into the West tub room. Using the Inspector's thermometer, it was observed by all that over the course of several minutes, the hot water temperature dropped from approximately 34 C down to 28 C. Following this, the hot water temperature at the sink, in the bathroom connected to the tub room, was measured and it was noted that the temperature went down while it was being observed.

7. On February 25, 2015, Inspector #133 spoke with resident #004, and asked if the resident had experienced cold water while being bathed. The resident specified that they choose to have a shower, and that they are showered in the South shower room during the day shift. The resident explained that on February 24th, 2015, during their hair wash, the shower water got so cool that it made them feel like they were choking. The resident said that the shower water temperature has to be put up to the highest level, and there are times it gets cold during the shower, without anything having been done to the dial. The resident explained that they keep a journal, and consulted it in order to give the Inspector further details. The journal was also shown to the inspector. The resident

indicated that December 25, 2014, there was no hot water to allow for a shower. On December 28, 2014, there was lukewarm to cold water only during the resident's shower. On January 1, 2015, there was a lack of hot water to allow for a shower and a hair wash, at 10:25am. The resident further added that in their bedroom, while they are brushing their teeth, with only the hot water on, it is not unusual that the water never gets hot.

On February 26th, 2015, Inspector #133 reviewed the daily flow sheets within resident #004's health care record. It was noted that during the time span of December 20th – 26th, 2014, it was documented that the resident received only one shower, on December 21st. The following week, Dec 22nd, 2014 - January 2nd, 2015, it was documented that the resident only received one shower, on December 28th, 2014. It is noted that on January 1st, 2015, nursing staff working the evening shift documented that hair care was provided to the resident. As per O. Reg. 79/10, s. 33 (1), each resident of the home is to be bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

8. On February 26th, 2015, in the South shower room, the inspector measured the temperature of the hot water from the shower. After letting the water run for 4 minutes, the inspector noted hot water temperatures at one minute intervals. Beginning at 10am, the temperatures monitored were as follows: 36.3 C, 36.4 C, 36.9 C, 37.2 C, 37.3 C, 37.3 C, 37.5 C, 37.6 C.

9. Evidence gathered through direct observation and discussion with staff and a resident during the inspection supports that the hot water serving all bathtubs and showers used by residents is not maintained at a temperature of at least 40 degrees Celsius. The widespread non-compliance described presents as a potential risk to the comfort, safety and well-being of residents.

10. During a telephone conversation, on March 9th, 2015, the Administrator explained to the Inspector that a new plumber had been in to the home. The Administrator indicated that this plumber had informed the home that the main water mixing valve in place was not the right kind, and that it was also not properly adjusted. The Administrator indicated that the mixing valve would be replaced. [s. 90. (2) (i)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 21 in that that the licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. This is specifically related to identified resident's bathrooms.

2. On February 25th, 2015, in an identified bedroom, resident #001 told Inspector #133 that their bathroom was often cold. The Inspector used their thermometer and after leaving it in place for 5 minutes, noted the temperature to be 19.4 degrees Celsius (C) at 11:55am. On February 26th, the Inspector returned to speak with resident #001, who indicated that they continued to find their bathroom cold on that day. Using the same process described above, the Inspector noted the bathroom temperature to be 19.5 C. Resident #001 told the Inspector that they do not wish to keep their bathroom door open, because they find it smells bad. The identified bedroom is a shared bedroom.

3. On February 25th, the following temperatures were found in the following identified bathrooms, using the method described above.

Room #136 – 18.8 C, at 12:44pm

Room #108 – 19.3 C, at 12:45pm

4. On February 26th, the following temperatures were found in the following identified bathrooms, using the method described above.

Room #136 – 18.4 C, at 10:20am

Room #100 – 19.4 C, at 10:25am

Room #B – 19.6 C, at 10:40am. Resident # 005, who resides in the identified bedroom, told the Inspector that they find their bathroom very cold, and that it's particularly cold to sit on the toilet.

Room #116 – 19.6 C, at 11:57am

Room #151 – 20.6 C, at 12:18am

It is noted that at the time of the inspection, there was no independent heat source in the residents' bathrooms. All temperatures noted above were taken in bathrooms where the door was closed when the Inspector first entered the bedroom.

This pattern of non-compliance presents a potential risk to the comfort and well being of the affected residents. [s. 21.]

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 with the requirement that all areas of the home, including resident's bathrooms, be maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #4: 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,
(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; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 87 (2) (b) (i) in that the licensee failed to ensure that a procedure was implemented for cleaning and disinfection of resident care equipment, such as whirlpools, in accordance with manufacturer's specifications.

2. On February 24th, 2015, while taking the temperature of the hot water serving the whirlpool bathtub in the West tub room, Inspector #133 observed that there was no bottle of disinfectant within the disinfectant chamber in the tub's control console. This was also observed at the whirlpool bath tub in the South tub room. This was notable to the Inspector because whirlpool tubs require an internal disinfection process, to ensure the jet lines are maintained in a sanitary condition. The Inspector noted signage on the walls in both tub rooms, dated February 20th, 2015, that directed staff to use disposable cleaning wipes to clean the tub after use and then to use disposable disinfection wipes (Virox brand "Accel" wipes) to disinfect the tub, prior to its next use. Later that day, the home's Administrator explained that the supply of tub disinfectant that is supposed to be used with the home's two whirlpool tubs had run out, and that more had not been ordered, because of uncertainty about dilution rates and product availability.

3. On February 25th, 2015, in the West tub room, PSW #S104 told the Inspector that there had been no tub disinfectant within the disinfectant chamber in the tub's control console for the last two weeks. On February 27th, 2015, the home's Director of Care

(DOC) told the Inspector that there hadn't been any tub disinfectant since about mid-February. The DOC explained that she worked with the office manager, on February 20th, 2015, to develop signage for the tub rooms, instructing staff to work with the cleaning and the disinfecting wipes that were currently available in the home.

4. On February 25th, 2015, resident # 004 told the Inspector that they had not been provided their scheduled shower on February 19th and 22nd, 2015, because there they were told there was no disinfectants for staff to use. The resident maintains a journal, and allowed the Inspector to read it. The relevant entry reads "19 & 22 Feb 2015, [PSW] said shower is not possible due to no disinfectants". On February 27th, 2015, the Inspector spoke with the Director of Care (DOC) about this. The DOC explained that this was a result of the PSWs misunderstanding, as the cleaning cloths and disinfectant wipes have always been available for use with the shower chair.

5. On February 27th, 2014, the Administrator provided the Inspector with the "Dolphin Bathing System Installation and Operation" Manual (Rev. C – Dec 2008). As per the manual, on page 28, the whirlpool tubs are to be disinfected after every use. The process that is to be followed includes a method for disinfecting the internal system of the whirlpool tub. This process requires that liquid disinfectant be run through the lines, by connecting the disinfection hose end into the "quick connect" on the inside of the tub wall. This process cannot be accomplished with disinfectant wipes, which only serve to disinfect the tub surface. After such a tub is used, water can be retained in the whirlpool jet lines, which may contain soap residue, skin cells, body oils, and microorganisms. It is for this reason that disinfection of the jet lines after every use is of critical importance.

6. On February 27th, 2015, the home's Director of Care provided the Inspector with a copy of the written procedure that has been developed for cleaning and disinfection of resident care equipment such as whirlpools. The home is using policies that have been developed by Extendicare Canada Inc. The policy was titled "Shower Spa Cleaning", with a reference number INFE-02-01-07, version January 2013. The policy directs that care staff be familiar with and follow the manufacturer's recommended method for cleaning and disinfecting all bathing units and associated bathing equipment. The policy emphasizes the daily importance of ensuring a sufficient quantity of cleaning/disinfecting solution is available, and instructs that a tub room or shower room be placed "out of service" if sufficient product is not available. Care staff are directed not to use a room that has been placed out of service, and to bathe residents in another tub room or shower room, until such time that cleaning/disinfecting solution is made available.

7. The written procedure on the walls in the tub rooms, developed by the home's DOC and office manager, was not in accordance with manufacturer's specifications. As well, the Extendicare policy was not implemented. A widespread potential risk to the residents, related to infection prevention and control, was created by this situation.

8. On March 9th, 2015, during a telephone conversation, the Administrator explained to the Inspector that the whirlpool plumbing had been dismantled and removed from the West unit tub, and the jet holes on the tub wall had been sealed. This had occurred during the week of March 2nd, 2015. The Administrator indicated that he expected the South unit tub would be done at some time during the week of March 9th, 2015. As well, the Administrator advised that on March 11th, 2015, it was expected that a new disinfectant dispensing system would be installed in both of the tub rooms, and staff training was being planned. [s. 87. (2) (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 with the requirement that a procedure is developed and implemented for cleaning and disinfection of resident care equipment, such as whirlpools, tubs, showers chairs and lift chairs, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based ptractices, to be implemented voluntarily.

Issued on this 23rd day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2015_346133_0005
Log No. / Registre no:	O-001534-15
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Mar 20, 2015
Licensee / Titulaire de permis :	1663432 ONTARIO LTD. 2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BIPIN RAUT

To 1663432 ONTARIO LTD., 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(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).

Order / Ordre :

In order to achieve compliance with LTCHA, 2007, S. O. 2007, c. 8, s. 15 (2) (a) and (c), the licensee will conduct a full home audit that is to include, but not be limited to, all areas/items captured within the grounds. The licensee will develop and implement a plan to address and remediate all areas and items of concern.

The licensee will ensure that, as required by O. Reg. 79/10, s. 90 (1) and (2), schedules and procedures are developed and implemented for routine, preventive and remedial maintenance, to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee will ensure that, as required by O. Reg. 79/10, s. 87 (2), procedures are developed and implemented for cleaning of the home, including wall surfaces, and cleaning and disinfection of resident care equipment, supplies and devices, and contact surfaces, to ensure that the home, furnishings and equipment are kept clean and sanitary.

The licensee will ensure that, as required by O. Reg. 79/10, s. 30, all required procedures are written. As well, as is required by O. Reg. 79/10, s. 8 (1) (a) and (b), all required procedures must be in compliance with and implemented in accordance with all applicable requirements under the Act; and, must be complied with.

The licensee will implement a routine auditing program, once all areas of concern are addressed, to ensure sustained compliance.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (a) in that the licensee has failed to ensure that the home is kept clean and sanitary.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Written Notification was issued,

a) Inspector #133 conducted an inspection at the home on February 24th – 27th, 2015. The following widespread non-compliance relating to cleanliness of walls and lower doors was observed throughout the inspection.

West dining room – The walls were very heavily soiled with dried food matter,

most pronounced in the area around the front area of the room, but notable throughout. As well, upon entry to the dining room, along the right wall, mid-way to the serving station, areas of the wall were dirty with dried sputum, as identified by a housekeeper, staff # S105. The housekeeper, and a dietary staff person in the area at the time of the conversation, explained that there is a resident who eats at the table closest to that area and who regularly spits on the walls and floor.

Bedroom A – In the bathroom, the wall across from the toilet, and the floor underneath, was very heavily soiled with thick accumulations of dried sputum. The outer bathroom door and surrounding walls were also very dirty with areas of dried sputum. The Inspector reported this to the Administrator at the end of the inspection day, on February 24th, 2015, and the bathroom and bedroom were thoroughly cleaned on February 26th, 2015.

Private Lounge – Lower walls throughout were dirty with dried matter and scuff marks. This was most pronounced next to the doorway, but notable throughout. The center pillar was similarly soiled.

Bedroom #115 – The lower bathroom wall, across from the toilet, was dirty with dried brown matter (under the towel bar and around the garbage can).

Bedroom #137 – The lower bathroom wall, to the left of the toilet, was dirty with spots of dried dark matter.

Bedroom #129 – The lower bathroom wall, to the left of the sink, was dirty with spots of dried dark brown matter.

Bedroom #127 – The lower bathroom walls, throughout, were dirty with spots of dried matter of various colours.

Bedroom #131 – The lower bathroom wall was dirty with spots of dried matter and scuff marks.

Bedroom #125 – The lower bathroom walls, throughout, were dirty with spots of dried brown matter.

Bedroom #135 – The lower bathroom walls, throughout, were dirty with spots of dried matter, most pronounced around the toilet.

Bedroom #145 – The lower bathroom walls were dirty with spots of dried dark matter.

Public bathroom within main entrance area – The lower walls were dirty with spots of dried brown matter throughout, scuff marks, and areas of what appeared to be dried toilet tissue paper or other such similar material.

It is to be noted that observations pertaining to the cleanliness of the public bathroom are related to complaint inspection # 2015-198117-0007 , log is # O-001456-14, which was conducted by Long Term Care Home Inspector # 117, concurrent with Inspector #133's inspection.

West staff bathroom – The lower wall next to the toilet was dirty with spots of dried dark coloured matter.

Bedroom #103 – Lower walls throughout the bedroom were dirty with dried matter (i.e. next to the bed, around the fridge, to the left of the bathroom door)

Main entrance lobby area and unit hallways – Lower walls throughout are dirty with spots of dried matter of various colour (i.e. outside of public bathroom, outside of janitors room and kitchen entrance, outside of the private lounge, to the left of the bird cage, outside of south dining room, outside of the south nurses' office, outside of room #146, throughout the south and west hallways, in the west activity room, south shower room, south activity room)

b) Exhaust vents – Throughout the inspection, Inspector #133 observed that exhaust vents in the following identified resident bathrooms were dirty with a heavy accumulation of dust: #140, #119, #121/123, #136, #130, #112, #128, #126, #118.
(133)

2. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Voluntary Plan of Correction was issued, and an immediate Compliance

Order was served on the licensee.

a) Inspector #133 conducted an inspection at the home on February 24th – 27th, 2015. Widespread non-compliance relating to the overall maintenance of the home was observed over the course of the inspection.

b) Flooring in identified residents' bathrooms, the South tub room, and the bathroom that serves the south tub and shower room:

i) Vinyl sheet flooring is in place in the identified areas. The flooring has shrunk and there is a loss of adhesion between the flooring and the concrete beneath in the majority of the areas. Along at least two of the 3 walls, in the majority of the areas, the flooring edges have curled, and pulled away from the baseboards, creating a gap ranging from approximately .5 inches to 1.5 inches. In a few cases, while the flooring has shrunk and pulled away from the baseboards, the edges remain flat. Accumulated dirt, debris, and in one case, pests, were observed within the gaps and beneath the loose flooring. For example, in the South tub room, along the gap and beneath the flooring, in the back left corner, the Inspector observed a heavy accumulation of sand and debris, and a number of small ants.

This flooring problem was observed in the following resident bedrooms: 122, 116, 114, 107, 137, 129, 125, 133, 135, 137, 147, 104, 128, 145.

ii) The vinyl sheet flooring in place in resident bathrooms is light brown in colour. In identified areas, the flooring was extensively discoloured with blackened areas and in some cases, scuff marks.

This flooring problem was observed in the following resident bedrooms: 118, 131, 133, 129, 145, 124

c) Lower wall surfaces in common areas:

Lower wall surfaces throughout the home were in a poor repair at the time of the inspection. Lower wall surfaces were gouged, pitted, chipped and peeling, and scuffed. Holes in walls were also observed in some areas, such as in the west dining room, the public bathroom, and in resident bathrooms #116 and #107. Also in the public bathroom, the baseboard was not adhered to the wall and was leaning outwards, behind and beside the toilet.

Identified areas of concern are as follows: Public bathroom, the South and West dining rooms, South tub and shower rooms, the main entrance area (i.e. around the kitchen and janitor doors, lower door leading into the private lounge), to varying degrees, throughout the South and the West unit hallways, West activity room, South activity room, bathroom #133 (damage patched but not finished, baseboard not adhered to wall).

It is to be noted that observations pertaining to the state of repair of the public bathroom are related to complaint inspection # 2015-198117-0007 , log is # O-001456-14, which was conducted by Long Term Care Home Inspector # 117, concurrent with Inspector #133's inspection.

d) Bathroom exhaust:

Throughout Inspector #133's initial tour of the South hallway, it was generally noted that the exhaust system in resident bathrooms, throughout, was unusually loud. When beginning observations in the West hallway, in bedroom #101, the Inspector could not detect any audible exhaust. Standing on a chair, the Inspector held a small piece of single ply tissue up to the vent, and found that there was no suction, causing the tissue to fall to the floor. This was done with the light on and off, as it was not clear if the exhaust system is dependent on the light being on or not. This was reported to a maintenance worker at the home, staff # S106, who later confirmed that there was no bathroom exhaust in bedroom #101, because the exhaust fan, within the ceiling, had been unplugged. He explained that the bathroom exhaust in resident's bathrooms is so loud because the fans are old, and the blades dulled. He explained that by replacing an old fan with a new one in a resident's bathroom, the exhaust system is rendered almost silent. This was the case in bedroom #105, where the Inspector had initially thought that the bathroom exhaust system was not functional, but had not tested for suction using a single ply tissue. The maintenance worker had followed up, and pointed out that there was a newer exhaust fan in this bathroom. Following discussion with the Inspector, the maintenance worker was going to check for exhaust in the following bedrooms that remained in question: #119, #135, #115, #147, #142, #100, #102, #108.

On February 25th, 2015, in an identified bedroom, resident #004 explained to the Inspector that they had found their bathroom exhaust was too loud, and that they had requested that the maintenance worker unplug it, on February 24th,

2015, as it was disturbing to them, particularly when resting. The resident explained that regardless of the position of the light switch, the exhaust system in their bathroom comes on at various noted times, such as between 7:12 am – 8:20 am, 11:10am – 12:10pm, and 4:17pm – 7:15pm. The resident went on to explain that the maintenance worker had replaced their bathroom exhaust fan with a new one, on February 25th, 2015. The resident remarked that the exhaust was now quiet, and was pleased with the intervention.

e) Handrails throughout the home:

The handrails in the unit hallways are wooden, and little to no surface finish remains, thereby exposing the porous wood beneath. These absorbent surfaces cannot be cleaned and disinfected.

f) It is noted that the maintenance worker in place at the time of the inspection, staff # S106, explained to the Inspector that he is currently implementing a comprehensive maintenance program at the home. This staff person explained to the Inspector that he has been brought in to help the home in the absence of the home's Environmental Supervisor, who has been away since mid to late December 2014.

g) The above observations made over the course of the 4 day inspection represent a widespread failure of the home's existing maintenance program, presenting a potential risk to the comfort, safety, and well being of the residents. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

In order to achieve compliance with O. Reg. 79/10, s. 90 (2) (g), the licensee will ensure that procedures are developed and implemented to ensure that 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.

The licensee will immediately develop and implement a contingency plan that all care staff are to follow in the event that the temperature of the hot water does not allow for a resident to be bathed, by the method of his or her choice, at the time of their scheduled bathing. As is required by O. Reg. 79/10, s. 33, the licensee will ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. As well, it is a resident's right to refuse bathing, at any time, and this is to be documented. All care staff who bathe residents must be trained in the contingency plan, and care staff must document if and when a resident can not be bathed at their scheduled time, and must document what follow up actions are taken. The Director of Care is to oversee this process, daily. As well, all care staff are to document if the hot water became cold during the bathing process, and what follow up actions were taken.

Once corrective actions are taken, the licensee is to implement a daily water temperature monitoring program at all bathtubs and showers used by residents, to ensure that the corrective actions have been effective and will result in compliance.

The required contingency plan and daily water temperature monitoring program is to remain in place until such time as the Compliance Order is complied.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 90 (2) (i) in that the licensee has not developed and implemented procedures to ensure that 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.

2. On February 24th, 2015, in the West tub room, Inspector #133 measured the temperature of the hot water at the bathtub. After running the water for 5 minutes, the Inspector measured the water temperature at 1 minute intervals, between 3:09pm and 3:16pm. The temperature dial was in its highest position.

The temperatures measured were as follows: 33 C, 40.3 C, 39 C, 35.5 C, 37.7 C, 40 C, 38 C, 37.3 C.

3. While in the West tub room, following the water temperature measurement process described above, a Personal Support Worker (PSW), staff #S100, told the Inspector that it is not unusual that the water at this tub goes cold while bathing residents. Another PSW, staff #S101, came along at the same time, and told the Inspector that there are times they get residents ready for a bath, get them up into the tub lift, but then there is no more hot water so they have to take them out of the lift and dress them again. Later that afternoon, in the West tub room, another PSW, staff #S102, told the Inspector that it's not unusual that the water at the bathtub goes from hot to cold while bathing a resident, and that the residents do not like it.

4. On February 24th, 2015, in the South tub room, a PSW, staff #S103, told the Inspector that the water temperature in the tub is not always stable. They said that they can have a resident in the tub, and while giving a tub shower, the water can get hot, then without doing anything at all, the water can get cold.

5. On February 25th, 2015, at 10:13am, the Inspector entered the West tub room and met a PSW, staff #S104 , who was running the tap in attempt to get warm water. The PSW (#S104) indicated that the water had been running for several minutes. It was noted that over two minutes, the hot water temperature went from 28 C down to 22 C. Beginning at 10:16am, the Inspector began noting the temperature at one minute intervals. The temperature measurements were as follows: 25.8 C, 23.1 C, 26 C, 31.3 C, 31.2 C, 33.5C, 35.5 C, 35.5 C, 35.7 C. The PSW (#S104) felt that the temperature of the hot water, at 35.7 C, was sufficient to bathe the resident who was waiting for a bath, resident #002. The Inspector left the West tub room, and the PSW proceeded with the bath. The Inspector returned to the West tub room at 11:07am, and spoke with the PSW again, to enquire about resident #002's bath. The PSW (#S104) clarified that they do not give residents a tub bath, only a tub shower, because due to the ongoing water temperature fluctuations, when the tub is left to fill up over a period of time, they often find the water is too cold to bathe a resident, and this wastes a full tub of water. The PSW (#S104) proceeded to explained that if they are using the shower wand, at least they can pull it away from the resident when it gets cold. Relating to resident #002, the PSW (#S104) explained that there had been sufficient supply of warm water for the resident's tub shower. The PSW indicated that they had showered another resident, #003, in the tub, after

resident #002, and that the water had gone cold during the process, causing resident #003 discomfort and to yell out at them that it was too cold.

6. On February 25, 2015, at 3:30pm, Inspector #133, the Administrator and the Office Manager went into the West tub room. Using the Inspector's thermometer, it was observed by all that over the course of several minutes, the hot water temperature dropped from approximately 34 C down to 28 C. Following this, the hot water temperature at the sink, in the bathroom connected to the tub room, was measured and it was noted that the temperature went down while it was being observed.

7. On February 25, 2015, Inspector #133 spoke with resident #004, and asked if the resident had experienced cold water while being bathed. The resident specified that they choose to have a shower, and that they are showered in the South shower room during the day shift. The resident explained that on February 24th, 2015, during their hair wash, the shower water got so cool that it made them feel like they were choking. The resident said that the shower water temperature has to be put up to the highest level, and there are times it gets cold during the shower, without anything having been done to the dial. The resident explained that they keep a journal, and consulted it in order to give the Inspector further details. The journal was also shown to the inspector. The resident indicated that December 25, 2014, there was no hot water to allow for a shower. On December 28, 2014, there was lukewarm to cold water only during the resident's shower. On January 1, 2015, there was a lack of hot water to allow for a shower and a hair wash, at 10:25am. The resident further added that in their bedroom, while they are brushing their teeth, with only the hot water on, it is not unusual that the water never gets hot.

On February 26th, 2015, Inspector #133 reviewed the daily flow sheets within resident #004's health care record. It was noted that during the time span of December 20th – 26th, 2014, it was documented that the resident received only one shower, on December 21st. The following week, Dec 22nd, 2014 - January 2nd, 2015, it was documented that the resident only received one shower, on December 28th, 2014. It is noted that on January 1st, 2015, nursing staff working the evening shift documented that hair care was provided to the resident. As per O. Reg. 79/10, s. 33 (1), each resident of the home is to be bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

8. On February 26th, 2015, in the South shower room, the inspector measured the temperature of the hot water from the shower. After letting the water run for 4 minutes, the inspector noted hot water temperatures at one minute intervals. Beginning at 10am, the temperatures monitored were as follows: 36.3 C, 36.4 C, 36.9 C, 37.2 C, 37.3 C, 37.3 C, 37.5 C, 37.6 C.

9. Evidence gathered through direct observation and discussion with staff and a resident during the inspection supports that the hot water serving all bathtubs and showers used by residents is not maintained at a temperature of at least 40 degrees Celsius. The widespread non-compliance described presents as a potential risk to the comfort, safety and well-being of residents.

10. During a telephone conversation, on March 9th, 2015, the Administrator explained to the Inspector that a new plumber had been in to the home. The Administrator indicated that this plumber had informed the home that the main water mixing valve in place was not the right kind, and that it was also not properly adjusted. The Administrator indicated that the mixing valve would be replaced.
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 20th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

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