Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2021	2021_623626_0008 (A1)	002541-21, 003998-21, 005085-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Thorntonview
186 Thornton Road South Oshawa ON L1J 5Y2

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

Amended by KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This Public inspection order report has been amended to reflect an extension of the compliance due date. A copy of the revised report is attached.

Issued on this 23rd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
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186 Thornton Road South Oshawa ON L1J 5Y2

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

Amended by KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 17, 18, 19, 20 and 31, June 1, 2, 3, 4, 7, 8, 2021. June 9, 2021 off-site.

The following intakes were inspected during this Complaint Inspection:

A complaint log related to concerns regarding nutritional care and weight changes.

A complaint log related to resident care including bathing.

A follow up to Compliance Order (CO) #001 related to s. 229. (4), issued in inspection #2021_643111_0002 with a compliance due date of Mar 31, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietitian, Infection Control Manager, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Support Workers (PSW), Dietary Aide, Chaplin, Screener, Housekeeper, resident and family member.

The inspector also reviewed applicable policies, resident health records, and internal reports, observed the delivery of resident care and services, including staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Safe and Secure Home

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

5 WN(s)
1 VPC(s)
1 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	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

A follow-up inspection was conducted pertaining to Compliance Order (CO) #001, related to O. Reg. 79/10, s. 229 (4) from inspection #2021_643111_0002 issued on Feb 25, 2021, with a compliance due date of Mar 31, 2021, and continued non-compliance was identified.

During the inspection, the following observations were made by the Inspector:

The order required leadership, monitoring and supervision of staff adherence with appropriate IPAC practices, such as the donning and doffing of personal protective equipment (PPE), and to ensure that appropriate precaution signage was posted. During an observation on an identified date in a resident home area, residents #005 and #006 were noted to be in separate rooms on this unit. Resident #005 was newly admitted to the home, and who was on contact/droplet precautions was observed outside the room with their mask not properly placed on the resident's face. The Assistant Director of Care (ADOC) indicated that resident #006 was placed on contact/droplet precautions for a specified duration, as the resident was symptomatic and was being treated. Resident #006's precaution was discontinued on the day of the observation. Both residents did not have isolation signage on their room doors and did not have isolation equipment readily available. On an identified date, Registered Practical Nurse (RPN) #126 an agency staff, went into the room to assist the resident and on exit, the RPN had no place to discard the PPE. Registered Practical Nurse #126 indicated that resident #005 was a new admission on contact/droplet precautions for a specified duration of time.

On another date, RPN #113 an agency staff working on an identified resident home area was observed exiting an isolation room of a newly admitted resident who was on contact/droplet precautions, without changing the mask or cleaning the face shield. Personal Support Worker (PSW) #123 donned PPE to enter the room of a newly admitted resident on an identified resident home area and when exiting the room, did not remove the dirty gloves in the process of doffing the PPE. Not adhering to infection control practices could result in the transmission of infection to residents.

In an interview, the Director of Care (DOC) indicated that staff must don and doff

PPE according to the kind of isolation. The appropriate signage must be posted and there must be a droplet/contact signage, donning and doffing instructions, and the reminder to wipe the face shield posted at the isolation room doors.

The licensee failed to ensure staff adherence to appropriate IPAC practices, specifically donning and doffing of PPE, and that appropriate precaution signage were posted for those residents on isolation for respiratory symptoms or for COVID-19 screening.

Sources: Observations; staff training records, interviews with PSW #123, RPN #113 and #126, ADOC and DOC.

2. The order also required that on the spot education and training was to be provided to staff not adhering with appropriate IPAC measures. A review of the audit records provided to the Inspector during the inspection, indicated that when infection control practice deficiencies were identified, no evidence was found that on the spot education and training was consistently provided, in a number of the audits that were performed by the home.

In an interview, the Infection Control Manager indicated that the auditor would correct staff, when there was a practice deficiency but did not note it and indicated speaking to the auditors about this concern. In another interview, the DOC indicated that the on-spot learning was not fully completed. It is the expectation that the on-spot learning was done.

The licensee failed to ensure that staff were consistently provided with on the spot education and training, when not adhering with appropriate infection prevention and control measures.

Sources: Donning/Doffing PPE Audit for Homes in COVID Outbreak, Putting on/Taking off PPE-Donning/Doffing PPE Audit and the Audit for Staff Entering/Exiting the Building Universal Mask; interviews with the Infection Prevention and Control Manager and the DOC. [s. 229. (4)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its residents, related to COVID-19 screening on entrance to the home.

Directive #3 date of issuance, May 4, 2021, and date of implementation May 4, 2021 directs that all individuals must be actively screened for symptoms and exposure history for COVID-19 before being allowed to enter the Long-Term Care Home (LTCH). Staff and visitors must be actively screened once per day at the beginning of their shift or visit.

On separate specified dates, staff #100, who was the screener at the front entrance did not ask all the required questions noted on the COVID-19 questionnaire, when Inspector #626 entered the home. Not asking the required questions on the questionnaire, and properly screening staff and visitors entering the home, could place the residents at risk for COVID-19 infection.

In an interview, staff #100 indicated that we ask these questions, if you have symptoms, fever, cough and sore throat, have you been out of the country and have you been close to a person with COVID without PPE. The Infection Control Manager indicated that they were using an incorrect version of the screening tool. In an interview, the DOC indicated that the screeners are to ask all the questions on the questionnaire.

The licensee has failed to ensure that staff and visitors are properly screened when entering the home, which could possibly expose the residents to COVID-19 infection.

Sources: screening tool, Screening - Guide -COVID-19; Interviews with staff (screener) #100, Infection Control Manager #109 and DOC. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, including at least two resident bedrooms in different parts of the home.

The licensee's Long -Term Care (LTC)-Heat Related Illness policy, directs that the air temperature and humidex will be monitored daily and on every shift on each resident home area (common areas), and values recorded on the Humidex Heat and Stress Response Recording form.

A review of the Humidex Heat and Stress Response Recording form for two identified resident home areas, revealed that there was no identification of the location where the air temperatures were taken on the resident home areas. The review of the Unit Temperatures forms for another two resident home areas, did not identify the specific locations where the temperatures were taken. The Thorntonview Air Temperatures form listed all four resident home areas but did not specify the location where the temperatures were taken. There was no

documentation found to support that the air temperatures were being monitored in two resident bedrooms in different parts of the home. Not monitoring the air temperatures in residents' rooms could increase the risk for heat related illness.

In an interview the DOC indicated that they had not started taking the air temperatures in two resident bedrooms. In another interview, RPN #112, indicated that temperatures were not being taken in resident rooms. Registered Nurse (RN) #102, indicated that the air temperature was checked only where the Barometer was located, which is close to the nursing station.

The licensee failed to ensure that the temperature was measured and documented in two resident bedrooms in different parts of the home.

Sources: LTC-Heat Related Illness policy; Humidex Heat and Stress Response Recording form; Unit Temperatures form; Thorntonview Air Temperatures form; interviews with RN #102, RPN #112 and the DOC. [s. 21. (2) 1.]

2. The licensee has failed to ensure that temperatures were measured under subsection (2) and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee's LTC-Heat Related Illness policy directs that the air temperature and humidex will be monitored daily and on every shift on each resident home area (common areas), and values recorded on the Humidex Heat and Stress Response Recording form.

A review of the Humidex Heat and Stress Response Recording form for a specified home area identified that, there was no documentation to indicate that the air temperature was measured on the day and evening shifts. The review of the Unit Temperatures forms for another specified resident home area identified that there was no documentation to indicate that the air temperature was measured on all shifts. The Thorntonview Air Temperatures form listed all four resident home areas but did not specify the location where the temperatures were taken. Each resident home area had one documented temperature measurement. Not monitoring the air temperatures in the home could increase the risk of residents for heat related illness.

In separate interviews with RPN #112 and RN #102, both indicated that temperature checks must be performed every shift. In an interview, the DOC

indicated that it is the expectation that the air temperature must be checked and documented every shift, but some units are not consistent.

The licensee failed to ensure that temperatures were measured under subsection (2) and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, as required under the regulation.

Sources: licensee's LTC-Heat Related Illness policy, Humidex Heat and Stress Response Recording form; Unit Temperatures forms; Thorntonview Air Temperatures form; interviews with RN #102, RPN #112 and the DOC. [s. 21. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall 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. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #002 was bathed at a minimum of twice a week by a method of his or her choice.

An anonymous complaint was received by the Director, regarding concerns with resident #002's care including bathing.

The review of the resident #002's written Care Plan, outlined that the resident required a shower with one staff to provide extensive assistance, and to refer to the bath/shower schedule. A review of the Bath List indicated that the resident is to be bathed twice during the week.

A review of the progress notes documentation indicated that the resident refused to have a shower on a number of dates. There was no documentation to indicate, that an alternate shower was offered or provided, except for one identified date. There were a number of dates identified in Point of Care (POC) that there was no documentation to indicate that a shower was refused or provided to the resident, and there was no documented entry in the progress notes. Not providing the scheduled shower could place the resident at risk for altered skin integrity.

During separate interviews, PSWs #116 and #117 indicated that if the resident refused the shower a bed bath could be provided, or the shower would be offered on an alternate day. Personal Support Worker #117 indicated that this would be documented in the progress notes. Personal Support Worker #116 also indicated that staff were not permitted to do baths or showers during the time when the home was in outbreak. In an interview, the DOC indicated, it is the expectation that staff document when baths or showers are not provided. When a resident refuse, it should be documented, and a replacement bath or shower should be offered.

The licensee failed to ensure that resident #002 was bathed at minimum of twice weekly, as there was no documentation that the resident was provided or offered a shower on a number of dates.

Sources: Resident #002 care plan, progress notes, POC report and Days Bath List; interviews with PSW #116 and 117 and the DOC. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee has failed to measure and record resident #003's monthly weight.

A complaint was received by the Director from the complainant regarding concerns related nutritional care and weight loss.

A review of resident #003's health record involving a five-month period, indicated that the resident was not weighed in a specified month. When the resident was weighed on the following month, weight loss was identified.

In an interview, RPN #103 indicated that resident #003's weight was not taken or recorded in the month identified, as the home was in outbreak. In another interview, PSW #132 indicated not being aware if the resident was weighed in the identified month. The DOC indicated that all resident weight must be completed before the seventh day of each month. The DOC also indicated that the home was short staff during that period and was in outbreak.

The licensee has failed to measure and record resident #003's monthly weight in accordance to the regulation, when the resident had experienced weight loss.

Sources: Resident #003's health records, interviews with PSW #132, RPN #103 and the DOC. [s. 68. (2) (e) (i)]

Issued on this 23rd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KARYN WOOD (601) - (A1)
Inspection No. / No de l'inspection :	2021_623626_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002541-21, 003998-21, 005085-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 23, 2021(A1)
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Thorntonview 186 Thornton Road South, Oshawa, ON, L1J-5Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Power

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 Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_643111_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must;

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate infection prevention and control (IPAC) practices, specifically donning and doffing of PPE and to ensure that appropriate precaution signage is posted for those residents on isolation for respiratory or COVID-19 screening or symptoms. Keep a documented record of the actions taken.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures. Keep a documented record.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

A follow-up inspection was conducted pertaining to Compliance Order (CO) #001, related to O. Reg. 79/10, s. 229 (4) from inspection #2021_643111_0002 issued on Feb 25, 2021, with a compliance due date of Mar 31, 2021, and continued non-compliance was identified.

During the inspection, the following observations were made by the Inspector:

The order required leadership, monitoring and supervision of staff adherence with appropriate IPAC practices, such as the donning and doffing of personal protective equipment (PPE), and to ensure that appropriate precaution signage was posted. During an observation on an identified date in a resident home area, residents #005 and #006 were noted to be in separate rooms on this unit. Resident #005 was newly admitted to the home, and who was on contact/droplet precautions was observed outside the room with their mask not properly placed on the resident's face. The Assistant Director of Care (ADOC) indicated that resident #006 was placed on contact/droplet precautions for a specified duration, as the resident was symptomatic and was being treated. Resident #006's precaution was discontinued on the day of the observation. Both residents did not have isolation signage on their room doors and did not have isolation equipment readily available. On an identified date, Registered Practical Nurse (RPN) #126 an agency staff, went into the room to assist the resident and on exit, the RPN had no place to discard the PPE. Registered Practical Nurse #126 indicated that resident #005 was a new admission on contact/droplet precautions for a specified duration of time.

On another date, RPN #113 an agency staff working on an identified resident home area was observed exiting an isolation room of a newly admitted resident who was on contact/droplet precautions, without changing the mask or cleaning the face shield. Personal Support Worker (PSW) #123 donned PPE to enter the room of a newly admitted resident on an identified resident home area and when exiting the room, did not remove the dirty gloves in the process of doffing the PPE. Not adhering to infection control practices could result in the transmission of infection to residents.

In an interview, the Director of Care (DOC) indicated that staff must don and doff PPE according to the kind of isolation. The appropriate signage must be posted and there must be a droplet/contact signage, donning and doffing instructions, and the reminder to wipe the face shield posted at the isolation room doors.

The licensee failed to ensure staff adherence to appropriate IPAC practices, specifically donning and doffing of PPE, and that appropriate precaution signage were posted for those residents on isolation for respiratory symptoms or for COVID-19 screening.

Sources: Observations; staff training records, interviews with PSW #123, RPN #113

and #126, ADOC and DOC.

2. The order also required that on the spot education and training was to be provided to staff not adhering with appropriate IPAC measures. A review of the audit records provided to the Inspector during the inspection, indicated that when infection control practice deficiencies were identified, no evidence was found that on the spot education and training was consistently provided, in a number of the audits that were performed by the home.

In an interview, the Infection Control Manager indicated that the auditor would correct staff, when there was a practice deficiency but did not note it and indicated speaking to the auditors about this concern. In another interview, the DOC indicated that the on-spot learning was not fully completed. It is the expectation that the on-spot learning was done.

The licensee failed to ensure that staff were consistently provided with on the spot education and training, when not adhering with appropriate infection prevention and control measures.

Sources: Donning/Doffing PPE Audit for Homes in COVID Outbreak, Putting on/Taking off PPE-Donning/Doffing PPE Audit and the Audit for Staff Entering/Exiting the Building Universal Mask; interviews with the Infection Prevention and Control Manager and the DOC. [s. 229. (4)]

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

Severity: Staff continued to demonstrate practice deficiencies in the adherence to infection prevention and control practices, including the donning and doffing of PPE. It was also identified from the documented evidence that on spot education and training was not consistently provided to staff when practice deficiencies were detected in the audits.

Scope: The scope of this non-compliance was a pattern based on the number of staff observations demonstrating infection control practice deficiencies. Several audit forms did not show documented evidence that on spot education and training was

consistently provided.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with O. Reg. 79/10, s. 229 (4). This subsection was issued as a CO on Feb 25, 2021, during inspection #2021_643111_0002, with a compliance due date of Mar 31, 2021. A VPC related to the same subsection was also was issued to the home in the past 36 months. (626)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

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

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

Issued on this 23rd day of September, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by KARYN WOOD (601) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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