Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

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## Public Copy/Copie 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 |
|---|---|---|---|
| Jul 29, 2021 | 2021_796754_0018 | 005612-21, 006072-21, 006265-21, 007150-21, 007461-21, 008002-21, 008396-21, 008681-21, 009407-21, 009808-21, 010167-21 | Critical Incident System |

**Licensee/Titulaire de permis**

Lutheran Homes Kitchener-Waterloo
2727 Kingsway Drive Kitchener ON N2C 1A7

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

Trinity Village Care Centre
2727 Kingsway Drive Kitchener ON N2C 1A7

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

TAWNIE URBANSKI (754), NUZHAT UDDIN (532)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 21-25, 28-30, July 2, 5 -9, 12, 2021.**

**The following intakes were completed during this Critical Incident inspection:**
**Log #005612-21, related to falls prevention and management,**
**Log #006072-21, related to falls prevention and management,**
**Log #006265-21, related to a medication involving drug diversion,**
**Log #007150-21, related to falls prevention and management,**
**Log #007461-21, related to falls prevention and management,**
**Log #008002-21, a follow up related to abuse/neglect of a resident by staff at the home,**
**Log #008396-21, an allegation of improper care of a resident by staff,**
**Log #008681-21, an allegation of abuse/neglect of a resident by staff,**
**Log #009407-21, related to falls prevention and management,**
**Log #009808-21, an allegation of improper treatment of a resident by staff, and**
**Log #010167-21, related to the unexpected death of a resident.**

**Amy Abbot, Inspector #694420 and Janis Shkilnyk, Inspector #706119 were present for this inspection.**

**NOTE: A Written Notification and Compliance Order related to O. Regulations 79/10, r. 36 was identified in a concurrent inspection #2021_796754_0019 (Log # 008497-21, and Log #009407-21) and issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Infection Control Lead, Facilities Manager, Human Resources Manager, RAI-Coordinator, Public Health Registered Nurse, Pharmacy Manager, Pharmacy Consultant, Falls Prevention Lead, Behavioral Support Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).**

**The inspector(s) also toured resident home areas, observed resident care provision, dining, resident to staff interaction, and reviewed relevant resident clinical records, IPAC practices and the home's relevant policies.**

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

**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**
**Skin and Wound Care**

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

- **7 WN(s)**
- **2 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #010 was not neglected by staff.

Ontario Regulation 79/10 s. 5 defines neglect as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #010 was transferred to the hospital after they sustained a fall and injury. The resident was discharged from the hospital and admitted back to the home with a required medical device and treatments.

Physiotherapist (PT) #126 provided staff with instructions for the required medical device and guided them to monitor resident #010's skin, and remove the medical device for skin inspection. PT #126 did not provide instructions for how often staff were to do this.

Orders were implemented for staff to remove resident #010's medical device twice per day to monitor and assess the skin. For a period of 5 days, staff documented that resident #010's skin was normal in colour and circulation, however according to staff, they were not removing the medical device for monitoring or assessing the skin.

Several days after the medical device was removed from resident #010 and altered skin integrity was discovered. There were complications with this and additional medications and treatments required. The medical device was discontinued.

PSW #128, 123, 122, and RPN #125 acknowledged that staff did not remove the medical device to monitor or assess resident #010's skin over a period of 9 days.

Failing to remove the medical device from resident #010 to assess and monitor the area for skin impairment resulted in the resident developing altered skin integrity, and contributed to their death.

Sources: CIS # 2580-000029-21, 2580-000026-21, 2580-000028-21, progress notes for resident #010, skin assessment, investigation notes, and interviews with PSW #122, #123, #128, RPN 125, Physiotherapist #126 , RN #127 and the DOC. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that medications were administered to residents #001, #004, and #005 in accordance with the directions for use as specified by the prescriber.

The home's management team became aware of an allegation that Registered Practical Nurse (RPN) #106 had been taking and consuming medications from the medication cart for over one year. RPN #106 confirmed that they were taking and consuming some of resident #001, #004, and #005's medications for over a year, but documenting in the residents' electronic medication administration record that the medications were administered to the residents.

The Inspector reviewed a pharmacy report for the three identified residents to determine the amount and length of time medications were not administered to residents #001, #004, and #005 as prescribed. The review period was completed from June 2019, until April 2021.

A) Resident #001 was prescribed an as needed (PRN) medication over a four month period. RPN #106 was the only staff member frequently documenting that this medication was administered. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 eight times. No other staff administered this medication.
ii. Month two: Documented administered by RPN #106 16 times. No other staff administered this medication.

iii. Month three: Documented administered by RPN #106 seven times.
iv. Month four: Documented administered by RPN #106 16 times. No other staff administered this medication.

B) 1. Resident #004 was prescribed a PRN medication over an four month period. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 four times.
ii. Month two: Documented administered by RPN #106 13 times.
iii. Month three: Documented administered by RPN #106 10 times.
iv. Month four: Documented administered by RPN #106 four times.

2. Resident #004 was prescribed a PRN medication over approximately two years. RPN #106 was the only staff member frequently documenting to administer this medication. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 21 times.
ii. Month two: Documented administered by RPN #106 30 times.
iii. Month three: Documented administered by RPN #106 28 times.
iv. Month four: Documented administered by RPN #106 30 times. No other staff administered this medication.
v. Month five: Documented administered by RPN #106 35 times.
vi. Month six: Documented administered by RPN #106 40 times. No other staff administered this medication.
vii. Month seven: Documented administered by RPN #106 41 times. No other staff administered this medication.
viii. Month eight: Documented administered by RPN #106 60 times. No other staff administered this medication.
ix. Month nine: Documented administered by RPN #106 44 times. No other staff administered this medication.
x. Month 10: Documented administered by RPN #106 64 times. No other staff administered this medication.
xi. Month 11: Documented administered by RPN #106 65 times. No other staff administered this medication.
xii. Month 12: Documented administered by RPN #106 64 times. No other staff administered this medication.
xiii. Month 13: Documented administered by RPN #106 56 times.
xiv. Month 14: Documented administered by RPN #106 66 times. No other staff

administered this medication.
xv. Month 15: Documented administered by RPN #106 58 times. No other staff administered this medication.
xvi. Month 16: Documented administered by RPN #106 53 times.
xvii. Month 17: Documented administered by RPN #106 23 times. No other staff administered this medication.
xviii. Month 18: Documented administered by RPN #106 67 times. No other staff administered this medication.
xix. Month 19: Documented administered by RPN #106 65 times. No other staff administered this medication.
xx. Month 20: Documented administered by RPN #106 63 times. No other staff administered this medication.
xxi. Month 21: Documented administered by RPN #106 60 times. No other staff administered this medication.
xxii. Month 22: Documented administered by RPN #106 62 times. No other staff administered this medication.
xxiii. Month 23: Documented administered by RPN #106 25 times. No other staff administered this medication.

C) Resident #005 was prescribed a PRN medication over a 10 month period. RPN #106 was the only staff member frequently documenting to administer this medication. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 two times.
ii. Month two: Documented administered by RPN #106 10 times.
iii. Month three: Documented administered by RPN #106 six times.
iv. Month four: Documented administered by RPN #106 11 times.
v. Month five: Documented administered by RPN #106 three times.
vi. Month six: Documented administered by RPN #106 six times.
vii. Month seven: Documented administered by RPN #106 six times. No other staff administered this medication.
viii. Month eight: Documented administered by RPN #106 11 times. No other staff administered this medication.
ix. Month nine: Documented administered by RPN #106 21 times. No other staff administered this medication.
x. Month 10: Documented administered by RPN #106 eight times.

Pharmacy consultant #138 reviewed the pharmacy report and said the medications

documented as administered by RPN #106 were likely diverted medications.

Video footage of RPN #106 from the home's surveillance camera's was reviewed for a five day period in 2021. It showed RPN #106 consuming several pills while standing by their medication cart, taking medications from the medication cart and then going to the medication room several times and putting medications from the medication cart into their pocket.

RPN #106 taking and consuming residents #001, #004, #005's medications, put the residents at risk for not receiving medications they required.

Sources: the home's video footage, investigation notes, pharmacy report, eMAR documentation, progress notes, quarterly medication reviews, and medication orders for resident's #001, #004, #005, interviews with DOC #101, ADOC #102, Human Resources Manager #108, Rai-Coordinator #115, Resident Care Coordinator #127, Pharmacy Consultant #138, Registered Practical Nurses, and Personal Support Workers. [s. 131. (2)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #001, #004, and #005's as needed (PRN) medications were reassessed at least quarterly and that the reassessment was documented.

1) Quarterly medication reviews were completed for resident #001 in February, 2021, October, 2020, and July, 2020.
2) Quarterly medication reviews were completed for resident #004 on February, 2021, November, 2020, and September, 2020.
3) Quarterly medication reviews were completed for resident #005 on February, 2021, November, 2020, and August, 2020.

The quarterly medication reviews documented the medication orders for residents #001, #004, and #005 and had a box to check off if the residents' medications would be continued or discontinued. The residents' PRN medication usage was not reassessed during these reviews, however new PRN medications were occasionally ordered, and existing PRN medications were often renewed and signed off by the physician and a registered staff.

Pharmacy consultant #138 said they did not complete quarterly medication reviews for residents #001, #004, and #005, from January 2020 to April 2021. They said the residents' PRN medications should have been reviewed during that time.

Director of Care (DOC) #101 said the pharmacy and physician would complete the quarterly medication reviews for residents, however, they would not review the amount of PRN medications given to a resident.

By not reassessing the PRN medication usage for residents #001, #004, and #005 at least quarterly, the safety and effectiveness of the medications were not evaluated.

Sources: Quarterly medication reviews for residents #001, #004, and #005, and interviews with DOC #101, and Pharmacy Consultant #138. [s. 134. (c)]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that safe transferring techniques were used when assisting residents #010 and #011.

DOC #101 said that residents who required staff to push them in their wheelchair, were required to have footrests in place when staff pushed them.

A) Resident #010 required footrests on their wheelchair when staff were pushing them. PSW #123 was pushing resident #010 in their wheelchair without footrests on a specified date. The resident's foot got caught under the wheelchair while being pushed, which caused them to fall, propel forward and sustain an injury.

The resident was diagnosed with an injury that required treatments and a medical device.

The resident passed away in the home several days later. The coroners report indicated the immediate cause of death was altered skin integrity, and the antecedent cause was the fall.

B) A complaint was received by the Director related to resident #011 being injured while being portered in their wheelchair by staff.

Resident #011 required footrests on their wheelchair when being transferred.

A staff member was portering resident #011 in their wheelchair without footrests. The resident's foot got caught on the floor and dragged beneath the wheelchair, which resulted in injury to the resident.

Failing to ensure that the footrests were used on resident #011's wheelchair resulted in pain and and injury to the resident..

Sources: resident #011, and #010's progress notes, Investigation forms, and care plan, and interviews with resident #011, RPN #106, PTA #105, and DOC #101. [s. 36.]

***Additional Required Actions:***

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

**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of resident #006, or unlawful conduct by a staff that resulted in risk of harm to a resident immediately reported the suspicion to the Director. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) Resident #006 told their Power of Attorney (POA) that they received a cold bath and were sprayed in the face with water by staff. The alleged abuse was reported to RN #127 by the resident's POA.

The home completed an investigation but failed to report the incident to the Director until several months later. By not reporting the incident immediately to the Director, the Director was unable to respond to the incident in a timely manner.

B) The home became aware of an allegation of unlawful conduct of RPN #106. Specifically the allegation was that RPN #106 was taking and consuming resident medications while working at the home.

RPN #114 said they noticed RPN #106 was the only staff member giving PRN narcotics

to resident #004 for two months. They believed the behavior to be odd and thus discussed it with another staff member but did not report it to a charge nurse or management at the home.

PSW #109 said they saw RPN #106 take an unlabeled bottle out of their purse and consume multiple different types of medications, some of which were cut. They also saw RPN #106 take medications from the medication cart and put the medications into a glove and then put the glove back into the medication cart. PSW #109 said they found RPN #106's behavior suspicious but they did not report it to anyone at the home.

PSW #110 said they saw RPN #106 consuming pills by the medication cart for over a one year period. They said they did not talk to RPN #106 about their behavior or report this to anyone at the home.

Staff not reporting RPN #106's suspicious behavior in relation to administration, consumption and storage of medications allowed the behavior to continue and put residents at actual risk of harm.

Sources: CI: 2580-000023-21, homes' investigation notes from December 2020, interviews with resident #006, PSW #109, #110, RPN #114, HR Manager #108, and DOC #101. [s. 24. (1)]

***Additional Required Actions:***

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

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

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

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that different approaches were considered when resident #001's plan of care was being reviewed and revised due to it being ineffective.

Resident #001 sustained several falls over a six week period.

Over a one week period, resident #001 sustained four falls. After the fourth fall the resident's plan of care was revised to include three new falls prevention interventions.

The resident sustained several additional falls after the revision of the plan of care. Three of these falls resulted in injury to the resident and two of them resulted in the resident being transferred to hospital. BSO RN #135 stated that frequent changes to the resident's medications during this time may have affected the resident's balance and contributed to the falls.

No revisions were made to the resident's plan of care for a period of five weeks despite them falling frequently during this time.

Failure to consider different approaches when resident #001 fell several times over a period of five weeks, resulted in the resident sustaining three falls with injuries, two of which required transfer to the hospital.

Sources; CI: 2580-000014-21, plan of care for resident #001, fall risk assessment, progress notes, observations, BSO RN #135. [s. 6. (11) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that different approaches are considered in the revision of the plan of care when the care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature**

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

**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 failed to ensure that the air temperature was measured and documented in writing, in at least one resident common area on every floor of the home, and two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation 79/10 included additional amendments related to cooling requirements and air temperatures in the LTC home.

A review of temperature records was completed for each floor at Trinity Village Care Center (TVCC).

On May 17, 18, 19, and 21, 2021, no resident common area temperatures were recorded at any of the required times for the first floor. On May 19, 21, 24, and 25, 2021, no resident common area temperatures were recorded at any of the required times for the second floor. On May 20, 21, 26, 27, 2021, no resident common area temperatures were recorded at any of the required times for the third floor.

A review of temperature records was completed for the entire home from May 17-27, 2021, which showed no temperatures were measured or documented after 1700 hours on any resident common areas or resident bedrooms throughout the home.

Facilities Manager #107 said that they were aware the home did not have the staff or equipment to measure or record any temperatures of the home on the evening or night shifts.

By not measuring and documenting air temperatures of the home, as required, the home would be unable to identify when a temperature related concern occurs. This may have put residents at risk for a temperature related illness.

Sources: record of the home’s documented air temperatures, and interview with facilities manager. [s. 21. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the air temperature is measured and documented in writing, in at least one resident common area on every floor of the home, and two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m., and once every evening or night, and that a record of the measurements are kept, to be implemented voluntarily.***

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**Issued on this 5th day of August, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Public Copy/Copie du rapport public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | TAWNIE URBANSKI (754), NUZHAT UDDIN (532) |
| **Inspection No. / No de l'inspection :** | 2021_796754_0018 |
| **Log No. / No de registre :** | 005612-21, 006072-21, 006265-21, 007150-21, 007461-21, 008002-21, 008396-21, 008681-21, 009407-21, 009808-21, 010167-21 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jul 29, 2021 |
| **Licensee / Titulaire de permis :** | Lutheran Homes Kitchener-Waterloo<br>2727 Kingsway Drive, Kitchener, ON, N2C-1A7 |
| **LTC Home / Foyer de SLD :** | Trinity Village Care Centre<br>2727 Kingsway Drive, Kitchener, ON, N2C-1A7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Debby Riepert |

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 Lutheran Homes Kitchener-Waterloo, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

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

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

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**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_800532_0007, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must comply with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

1) Ensure that residents are not neglected by staff in the home.
2) Ensure that when a resident returns to the home from hospital with prescribed treatment/interventions, that the treatment/interventions and related instructions are documented in their plan of care within 24 hours.
3) Ensure staff implement, monitor and document the effectiveness of the treatment/interventions as required.

**Grounds / Motifs :**

1. Compliance order #001 related to O. Reg 79/10, s. 19 (1) from inspection #2021_800532_0007 issued May 19, 2021 is being re-issued as follows:

The licensee has failed to ensure that resident #010 was not neglected by staff.

Ontario Regulation 79/10 s. 5 defines neglect as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #010 was transferred to the hospital after they sustained a fall and injury. The resident was discharged from the hospital and admitted back to the home with a required medical device and treatments.

Physiotherapist (PT) #126 provided staff with instructions for the required medical device and guided them to monitor resident #010's skin, and remove the medical device for skin inspection. PT #126 did not provide instructions for how often staff were to do this.

Orders were implemented for staff to remove resident #010's medical device twice per day to monitor and assess the skin. For a period of 5 days, staff documented that resident #010's skin was normal in colour and circulation, however according to staff, they were not removing the medical device for monitoring or assessing the skin.

Several days after the medical device was removed from resident #010 and altered skin integrity was discovered. There were complications with this and additional medications and treatments required. The medical device was discontinued.

PSW #128, 123, 122, and RPN #125 acknowledged that staff did not remove the medical device to monitor or assess resident #010's skin over a period of 9 days.

Failing to remove the medical device from resident #010 to assess and monitor the area for skin impairment resulted in the resident developing altered skin integrity, and contributed to their death.

Sources: CIS # 2580-000029-21, 2580-000026-21, 2580-000028-21, progress notes for resident #010, skin assessment, investigation notes, and interviews with PSW #122, #123, #128, RPN 125, Physiotherapist #126 , RN #127 and the DOC.

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

Severity: Not removing the medical device to assess resident #010 for skin impairment led to serious harm when the resident developed altered skin integrity that contributed to their death.

Scope: This was an isolated case as no other incidents of neglect were identified

during this inspection.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 19 (1) of O. Reg 79/10. This subsection was issued as a CO on May 19, 2021, during inspection #2021_800532_0007 with a compliance due date of May 28, 2021.
(532)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 10, 2021

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / No d'ordre :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

**Order / Ordre :**

The licensee must comply with s. 131. (2) of O. Reg 79/10.

Specifically the licensee must ensure:

1) That drugs are administered to residents #001, #004, and #005 in accordance with the directions for use specified by the prescriber.
2) RPN #106 receives education on the College of Nurses' of Ontario most current Medical Practice Standard before they return to work. A record of this staff members attendance as well as sign off of their understanding of the education is to be kept in the home.

**Grounds / Motifs :**

1. The licensee failed to ensure that medications were administered to residents #001, #004, and #005 in accordance with the directions for use as specified by the prescriber.

The home's management team became aware of an allegation that Registered Practical Nurse (RPN) #106 had been taking and consuming medications from the medication cart for over one year. RPN #106 confirmed that they were taking and consuming some of resident #001, #004, and #005's medications for over a year, but documenting in the residents' electronic medication administration record that the medications were administered to the residents.

The Inspector reviewed a pharmacy report for the three identified residents to determine the amount and length of time medications were not administered to residents #001, #004, and #005 as prescribed. The review period was completed from June 2019, until April 2021.

A) Resident #001 was prescribed an as needed (PRN) medication over a four month period. RPN #106 was the only staff member frequently documenting that this medication was administered. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 eight times. No other staff administered this medication.
ii. Month two: Documented administered by RPN #106 16 times. No other staff administered this medication.
iii. Month three: Documented administered by RPN #106 seven times.
iv. Month four: Documented administered by RPN #106 16 times. No other staff administered this medication.

B) 1. Resident #004 was prescribed a PRN medication over an four month period. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 four times.
ii. Month two: Documented administered by RPN #106 13 times.
iii. Month three: Documented administered by RPN #106 10 times.
iv. Month four: Documented administered by RPN #106 four times.

2. Resident #004 was prescribed a PRN medication over approximately two years. RPN #106 was the only staff member frequently documenting to administer this medication. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 21 times.
ii. Month two: Documented administered by RPN #106 30 times.
iii. Month three: Documented administered by RPN #106 28 times.
iv. Month four: Documented administered by RPN #106 30 times. No other staff administered this medication.
v. Month five: Documented administered by RPN #106 35 times.
vi. Month six: Documented administered by RPN #106 40 times. No other staff administered this medication.
vii. Month seven: Documented administered by RPN #106 41 times. No other staff administered this medication.
viii. Month eight: Documented administered by RPN #106 60 times. No other staff administered this medication.

ix. Month nine: Documented administered by RPN #106 44 times. No other staff administered this medication.
x. Month 10: Documented administered by RPN #106 64 times. No other staff administered this medication.
xi. Month 11: Documented administered by RPN #106 65 times. No other staff administered this medication.
xii. Month 12: Documented administered by RPN #106 64 times. No other staff administered this medication.
xiii. Month 13: Documented administered by RPN #106 56 times.
xiv. Month 14: Documented administered by RPN #106 66 times. No other staff administered this medication.
xv. Month 15: Documented administered by RPN #106 58 times. No other staff administered this medication.
xvi. Month 16: Documented administered by RPN #106 53 times.
xvii. Month 17: Documented administered by RPN #106 23 times. No other staff administered this medication.
xviii. Month 18: Documented administered by RPN #106 67 times. No other staff administered this medication.
xix. Month 19: Documented administered by RPN #106 65 times. No other staff administered this medication.
xx. Month 20: Documented administered by RPN #106 63 times. No other staff administered this medication.
xxi. Month 21: Documented administered by RPN #106 60 times. No other staff administered this medication.
xxii. Month 22: Documented administered by RPN #106 62 times. No other staff administered this medication.
xxiii. Month 23: Documented administered by RPN #106 25 times. No other staff administered this medication.

C) Resident #005 was prescribed a PRN medication over a 10 month period. RPN #106 was the only staff member frequently documenting to administer this medication. The pharmacy report showed the following:

i. Month one: Documented administered by RPN #106 two times.
ii. Month two: Documented administered by RPN #106 10 times.
iii. Month three: Documented administered by RPN #106 six times.
iv. Month four: Documented administered by RPN #106 11 times.

v. Month five: Documented administered by RPN #106 three times.
vi. Month six: Documented administered by RPN #106 six times.
vii. Month seven: Documented administered by RPN #106 six times. No other staff administered this medication.
viii. Month eight: Documented administered by RPN #106 11 times. No other staff administered this medication.
ix. Month nine: Documented administered by RPN #106 21 times. No other staff administered this medication.
x. Month 10: Documented administered by RPN #106 eight times.

Pharmacy consultant #138 reviewed the pharmacy report and said the medications documented as administered by RPN #106 were likely diverted medications.

Video footage of RPN #106 from the home's surveillance camera's was reviewed for a five day period in 2021. It showed RPN #106 consuming several pills while standing by their medication cart, taking medications from the medication cart and then going to the medication room several times and putting medications from the medication cart into their pocket.

RPN #106 taking and consuming residents #001, #004, #005's medications, put the residents at risk for not receiving medications they required.

Sources: the home's video footage, investigation notes, pharmacy report, eMAR documentation, progress notes, quarterly medication reviews, and medication orders for resident's #001, #004, #005, interviews with DOC #101, ADOC #102, Human Resources Manager #108, Rai-Coordinator #115, Resident Care Coordinator #127, Pharmacy Consultant #138, Registered Practical Nurses, and Personal Support Workers.

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

Severity: There was actual risk of harm to residents when their PRN medications were not administered to them as prescribed.

Scope: This non-compliance was widespread as three out of three residents reviewed did not have their PRN medications administered as prescribed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 131 (2) and one voluntary plan of correction was issued to the home. (754)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Aug 10, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

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**Order # / No d'ordre :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

**Order / Ordre :**

The licensee must comply with s. 134. (c) of O. Reg 79/10.

Specifically, the licensee must:

1) Ensure that all medications, including as needed (PRN) medications and the amount administered to residents is reassessed at least quarterly by the physician and registered staff and that this is documented.
2) Ensure that if concerns are identified, a medication incident and investigation are completed with corrective actions implemented.

**Grounds / Motifs :**

1. The licensee failed to ensure that resident #001, #004, and #005's as needed (PRN) medications were reassessed at least quarterly and that the reassessment was documented.

1) Quarterly medication reviews were completed for resident #001 in February, 2021, October, 2020, and July, 2020.
2) Quarterly medication reviews were completed for resident #004 on February, 2021, November, 2020, and September, 2020.

3) Quarterly medication reviews were completed for resident #005 on February, 2021, November, 2020, and August, 2020.

The quarterly medication reviews documented the medication orders for residents #001, #004, and #005 and had a box to check off if the residents' medications would be continued or discontinued. The residents' PRN medication usage was not reassessed during these reviews, however new PRN medications were occasionally ordered, and existing PRN medications were often renewed and signed off by the physician and a registered staff.

Pharmacy consultant #138 said they did not complete quarterly medication reviews for residents #001, #004, and #005, from January 2020 to April 2021. They said the residents' PRN medications should have been reviewed during that time.

Director of Care (DOC) #101 said the pharmacy and physician would complete the quarterly medication reviews for residents, however, they would not review the amount of PRN medications given to a resident.

By not reassessing the PRN medication usage for residents #001, #004, and #005 at least quarterly, the safety and effectiveness of the medications were not evaluated.

Sources: Quarterly medication reviews for residents #001, #004, and #005, and interviews with DOC #101, and Pharmacy Consultant #138.

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

Severity: There was minimal risk of harm to residents #001, #004, and #005 when their PRN medications were not reassessed at least quarterly and the safety and effectiveness of the medications were not evaluated.

Scope: This non-compliance was widespread as three out of three residents reviewed did not have their PRN medications reassessed at least quarterly.

Compliance History: Seven written notifications (WNs), seven voluntary plans of correction (VPCs) and three compliance orders (COs) were issued to the home

related to different sections of the legislation in the past 36 months.
(754)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2021

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

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**Order # / No d'ordre :** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee must comply with s. 36 of O. Reg 79/10.

Specifically, the licensee must:

1) Ensure that residents who are required to have footrests in place on their wheelchairs are not portered by staff without them.
2) Provide education to all staff who may be portering residents in the home on the safe use of footrests and the homes policy for safe transfers. A written record of this education must be kept including who completed the education, the content, and the date staff completed it.

**Grounds / Motifs :**

1. The licensee failed to ensure that safe transferring techniques were used when assisting residents #010 and #011.

DOC #101 said that residents who required staff to push them in their wheelchair, were required to have footrests in place when staff pushed them.

A) Resident #010 required footrests on their wheelchair when staff were pushing them. PSW #123 was pushing resident #010 in their wheelchair without footrests on a specified date. The resident's foot got caught under the wheelchair while being pushed, which caused them to fall, propel forward and sustain an injury.

The resident was diagnosed with an injury that required treatments and a medical device.

The resident passed away in the home several days later. The coroners report

indicated the immediate cause of death was altered skin integrity, and the antecedent cause was the fall.

B) A complaint was received by the Director related to resident #011 being injured while being portered in their wheelchair by staff.

Resident #011 required footrests on their wheelchair when being transferred.

A staff member was portering resident #011 in their wheelchair without footrests. The resident's foot got caught on the floor and dragged beneath the wheelchair, which resulted in injury to the resident.

Failing to ensure that the footrests were used on resident #011's wheelchair resulted in pain and and injury to the resident..

Sources: resident #011, and #010's progress notes, Investigation forms, and care plan, and interviews with resident #011, RPN #106, PTA #105, and DOC #101.

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

Severity: Not ensuring footrests where on resident #010, and #011's wheelchairs when staff were portering them caused actual harm to the residents.

Scope: This incident was a pattern as staff used unsafe transfer techniques for two out of three residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 36 and one compliance order was issued. (754)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2021

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

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**Order # / No d'ordre :** 005

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

**Order / Ordre :**

The licensee must comply with s. 24 (1) of the LTCHA.

Specifically, the licensee must:

1) Ensure that any staff who has reasonable grounds to suspect that abuse of a resident has occurred or unlawful conduct of a staff member that resulted in risk of harm to a resident immediately report the suspicion and the information upon which it is based to the Director.
2) Ensure that all staff receive re-education on the home's duty to report and mandatory reporting policy. A written record of this education must be kept including who completed the education, the content, and the date staff completed it.

**Grounds / Motifs :**

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of resident #006, or unlawful conduct by a staff that resulted in risk of harm to a resident immediately reported the suspicion to the Director. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A) Resident #006 told their Power of Attorney (POA) that they received a cold bath and were sprayed in the face with water by staff. The alleged abuse was reported to RN #127 by the resident's POA.

The home completed an investigation but failed to report the incident to the Director until several months later. By not reporting the incident immediately to the Director, the Director was unable to respond to the incident in a timely manner.

B) The home became aware of an allegation of unlawful conduct of RPN #106. Specifically the allegation was that RPN #106 was taking and consuming resident medications while working at the home.

RPN #114 said they noticed RPN #106 was the only staff member giving PRN narcotics to resident #004 for two months. They believed the behavior to be odd and thus discussed it with another staff member but did not report it to a charge nurse or management at the home.

PSW #109 said they saw RPN #106 take an unlabeled bottle out of their purse and consume multiple different types of medications, some of which were cut. They also saw RPN #106 take medications from the medication cart and put the medications into a glove and then put the glove back into the medication cart. PSW #109 said they found RPN #106's behavior suspicious but they did not report it to anyone at the home.

PSW #110 said they saw RPN #106 consuming pills by the medication cart for over a one year period. They said they did not talk to RPN #106 about their behavior or report this to anyone at the home.

Staff not reporting RPN #106's suspicious behavior in relation to administration, consumption and storage of medications allowed the behavior to continue and put residents at actual risk of harm.

Sources: CI: 2580-000023-21, homes' investigation notes from December 2020, interviews with resident #006, PSW #109, #110, RPN #114, HR Manager #108, and DOC #101.

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

Severity: There was actual risk of harm to residents when the licensee failed to report allegations of abuse or unlawful conduct of a staff immediately to the Director.

Scope: This non-compliance was a pattern as the licensee did not immediately report two incidents out of three reviewed to the Director.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 24 (1) and one compliance order was issued to the home.

(532)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2021

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 29th day of July, 2021**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Tawnie Urbanski

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office