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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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
May 11, 2021	2021_797740_0007 (A1)	003849-21, 003964-21	Complaint

Licensee/Titulaire de permis

QCC Corp.
3942 West Graham Place London ON N6P 1G3

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

Watford Quality Care Centre
344 Victoria Street Watford ON N0M 2S0

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

Amended by SAMANTHA PERRY (740) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On May 10, 2021, an email request for an extension of the compliance due date (CDD) of May 12, 2021, for Compliance Order #001 and #002 issued in inspection report #2021_797740_0007 was received from Tanya McGill, Administrator for Watford Quality Care LCTH. The Administrator requested a two-week extension from the original CDD of May 12, 2021 to help complete the ordered education for all staff due to unforeseen staff absences related to COVID-19. After an email discussion on May 10, 2021 with home management, LSAO Inspection Managers and Inspectors an extension was agreed upon with a new compliance due date of May 26, 2021.

Issued on this 11st day of May, 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

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Amended by SAMANTHA PERRY (740) - (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): March 18, 19, 22, 23(off site), 24, 25, 26(off site), 29, 30 and 31, 2021.

The following intakes were completed within this Complaint and Follow Up inspections:

Log# 003964-21 / IL-88223-LO related to an anonymous complaint regarding allegations of resident neglect; and

Log# 003849-21 / Compliance Order (CO) #001 related to the active screening of all persons for COVID-19 when entering the home.

During the course of the inspection, the inspector(s) spoke with the Owner of the home, the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Physiotherapists, Housekeeping, Maintenance, Security Guards, the locally designated Public Heath Unit, Personal Support Workers and residents.

The inspector(s) also made observations and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

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

- **14 WN(s)**
- **11 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 :

1. The licensee has failed to ensure that the home was a safe and secure environment related to the failure to maintain infection prevention and control measures specified in Directive #3 and relevant guidance documents, regarding the immediate implementation of active screening of all people, including but not limited to staff and visitors entering the home, to protect residents from COVID-19.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2021_797740_0003 issued on March 04, 2021, with a compliance

due date of March 06, 2021.

The licensee was ordered to ensure that they were compliant with s. 5 of the LTCHA.

Specifically, the licensee was ordered to:
- Follow Directive #3 and the applicable guidance documents related to the active screening of all people, including but not limited to, staff and visitors entering the Long-Term Care home.

The home failed to meet CO #001.

The licensee has failed to ensure that the home was a safe and secure environment when all persons, including inspectors #740 and #563 were not actively screened for COVID-19 upon their entrance and exit of the home.

During a night shift inspectors arrived at the home and were greeted by Personal Support Workers (PSW) #114 and #115. The PSWs unlocked the front entrance of the home, inspectors entered and the two PSWs then left the front entrance area without any direction provided to inspectors regarding active screening requirements. Inspectors screened themselves and then spoke with Security Guard (SG) #112 located at the rear entrance of the home. SG #112 said, it was their understanding they were responsible for actively screening all staff and visitors entering the home from the rear entrance and it was the staff's responsibility to actively screen any persons entering the home through the front entrance. Registered Nurse (RN) #102 and #105, and Registered Practical Nurse (RPN) #110 said it was their understanding that during the day anyone entering the home through the front entrance was actively screened by the ward clerk. Registered staff, either an RN or RPN on evenings and the RN on nights were responsible for actively screening all persons entering the front entrance of the home during the evening and night shifts. During the same night shift inspectors exited the home without being screened.

During an additional three separate shifts throughout the inspection, inspectors were not actively screened by registered staff for COVID-19 when entering at the front entrance of the home. Administrator #100 said it was their expectation and registered staff were aware of their responsibility to actively screen any visitors, including inspectors, entering the home through the front entrance. Administrator #100 said that registered staff did not actively screen inspectors upon their

entrance and exit of the home consistently and should have. The risk to all residents increased when the licensee failed to actively screen all visitors for COVID-19 when entering and exiting the home. [s. 5.]

Sources: Directive #3 (dated March 30, 2020 and December 09, 2020); MOH guidance documents - COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH) dated April 01, 2020 & COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes dated April 24, 2020; the home's policies and documents pertaining to the active screening of staff and visitors entering the home, observations at the front and back entrance of the home, interviews with registered and non-registered staff, the Director of Care and the Administrator.

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, was complied with.

An anonymous complaint received by the Ministry of Long-Term Care (MLTC) reported allegations of neglect related to the personal care of multiple residents.

The "Prevention, Elimination and Reporting of Abuse" policy, effective March 2018 documented, all staff members were and that "neglect" included "staff neglect" whether intentional or not, was also a form of abuse and the same mandatory reporting requirements applied.

Resident #002's clinical records documented an allegation of abuse and staff verified they did not report the allegation to the management team according to the home's, "Prevention, Elimination and Reporting of Abuse" policy.

Administrator #100 and Director of Care (DOC) #101 said, they were not aware of either the anonymous complaint reported to the MLTC or resident #002's allegation of physical abuse. Administrator #100 and DOC #101 said, it was their expectation that all staff members report any suspected or witnessed resident neglect and or resident abuse, immediately to the charge nurse and or directly to management.

Sources: The home’s Prevention, Elimination and reporting Abuse policy and interviews with management and staff. [s. 20. (1)]

Additional Required Actions:

CO # - 002 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# 002

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have his or her personal health information kept confidential.

The "PUBLIC INFORMATION" binder was observed at the main entrance of the home and accessible to anyone. The Inspection Reports tab of the binder included a copy of two different Critical Incident System (CIS) Reports, which contained resident names and specific resident health information. There was also a copy of a Licensee Report.

Administrator #100 verified there was personal health information (PHI) posted in the "PUBLIC INFORMATION" binder at the front of the home accessible to anyone and should not have been.

Sources: Critical Incident System (CIS) Reports, Licensee Report, Public Information binder, and Administrator interview. [s. 3. (1) 11. iv.]

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 by ensuring every resident has his or her personal health information kept confidential,, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

There was an anonymous complaint related to a resident's bathing schedule.

The resident's clinical records were reviewed, which documented conflicting bathing routines, which was verified by a registered staff member.The risk of not receiving their bathing routine according to their preference increased when the resident's plan of care was not reviewed and revised to reflect the resident's current bathing routine.

Sources: Interviews with management and registered and non-registered staff, review of the home's "Bathing List" and review of the resident's electronic medical records. [s. 6. (10) (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 by ensuring resident #006's and all other residents' plans of care are reviewed and revised to reflect the residents' current care requirements,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by resident #013, resident #007 and staff at all times.

There was an anonymous complaint related to the call bell system.

Resident #013 was observed, on multiple days and at different times, and each time the call bell was inaccessible. Resident #007 was observed and asked an Inspector to help them because they did not know where their call bell was and could not access it.

The QCC Corp Watford Quality Care Centre Call Bell Policy effective January 2021 documented, “for helpless residents who are not confused, the call bell needs to be in their hand” and “other residents need to have the call bell within reach.”

A Personal Support Worker (PSW) #104 could not find the end of resident #013’s call bell and could not easily access the call bell. PSW #104 verified it was not accessible. The Director of Care (DOC) #101 stated resident #013 does use the call bell unlike resident #007. Resident #007 was observed activating their call bell. Both call bells were not easily seen by the residents or staff preventing access and requests for assistance.

Sources: resident observations, resident clinical record reviews, QCC Corp Watford Quality Care Centre Call Bell Policy, staff and resident interviews. [s. 17. (1) (a)]

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 by ensuring all call bells can be easily seen, accessed and used by residents at all times,, to be implemented voluntarily.

WN #6: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect staff to resident #019 verbal abuse immediately reported the suspicion and the information upon which it was based to the Director.

An anonymous complaint was received by the Ministry of Long-Term Care (MLTC) related to the home's complaint process.

The home’s complaint binder documented a verbal complaint from resident #017 alleging staff to resident verbal abuse involving resident #019. The allegation was reported to Director of Care (DOC) #101.

The home's Complaints policy effective January 2021, documented that if any complaint made by anyone, including an employee, was related to resident abuse or possible harm to a resident, they were to follow the procedures documented in the home's Prevention, Elimination and Reporting of Abuse policy.

The “Prevention, Elimination and Reporting of Abuse" policy, effective February 2021 documented that any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished the resident’s sense of well-being, dignity or self-worth that was made by anyone other than a resident, was to be immediately reported to registered staff and or management.

DOC #101 verified, resident #017's description of the incident supported the legislative and policy definition of verbal abuse, and the allegation was not reported to the Director and should have been. There was an increased risk to residents #017 and #019 when the home failed to report the allegation to the Director. Reporting allegations of suspected abuse to the MLTC would have served to protect the residents.

Sources: Review of the home’s policies; Prevention, Elimination and reporting of Abuse and Complaints [s. 24. (1)]

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 by ensuring that when a person who had reasonable grounds to suspect that 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, that the suspicion and the information upon which it is based, is immediately reported to the Director., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment with respect to health conditions and other special needs.

There was an anonymous complaint related to care concerns for resident #001's other special needs.

Resident #001 clinical records were reviewed and reflected that the resident was assessed in accordance with best practice related to their current care requirements including the changing, cleaning and monitoring required to meet the resident's other special needs.

The QCC Corp Watford Quality Care Centre policy did not provide care instructions for Personal Support Workers (PSW) and PSW staff were not consistent in their description of the required changing, cleaning and monitoring of the resident's other special needs. The storage of the resident's devices were together in the resident’s shared bathroom and nursing staff could not determine

the age of the devices or how many times the devices had been reused for resident #001.

The Director of Care (DOC) #101 stated staff were to follow the expectations in the QCC Corp Watford Quality Care Centre policy. The DOC also verified the policy only spoke to the process for registered staff, and it did not speak to PSW expectations. The DOC stated the devices needed to be cleaned and stored in a designated area and registered staff should be dating the device when the entire device was changed. The DOC shared that at the time of the inspection, PSWs would not know how many times a device was reused, and the nursing staff would not know how old the devices were if there were multiple devices in the resident's bathroom without a date.

The devices for reuse were never observed as labelled with the date to ensure the assessed needs of the resident were met related to cleaning and monitoring of the resident's other special needs according to best practice guidelines. Furthermore, according to the electronic medical record, the order to check the resident's device daily and change as needed was not clearly documented to distinguish between whether the device was just checked or changed or both. There was an increased risk to resident #001 when their plan of care did not provide consistent care processes related to their other special needs to prevent infection and other complications.

Sources: resident and staff interviews, clinical record reviews, observations and review of relevant home policies. [s. 26. (3) 10.]

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 by ensuring any residents' plan of care, at a minimum, is based on an interdisciplinary assessment with respect to their health conditions and other special needs,, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 received oral care with the assistance required to ensure the integrity of the oral tissues were maintained.

Resident #007 said, their teeth were not cleaned every day, only on their bath days and they would remove food that was lodged between their teeth with their tongue.

Staff member #119 said, it was their understanding that residents would receive mouth care every day in the morning and evening.

On a different day resident #007 said, they did not receive their morning mouth care and would have liked to of had their teeth brushed. Staff member #126 said, they ran out of time. Inspector followed-up and resident #007 was observed brushing their teeth independently. Inspector then followed-up again and an observation of the resident's oral cavity showed white debris between the resident's teeth. The risk of altered oral tissue integrity for resident #007 increased when the licensee failed to ensure the resident's oral care was completed.

Sources: Record review, observations, resident and staff interviews. [s. 34. (1)]

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 by ensuring resident #007 and any other resident receives oral care with the assistance required to maintain the integrity of the oral tissues that includes, morning and evening mouth care, and the physical assistance or cuing required to help a resident who cannot, for any reason, brush his or her own teeth,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for remedial maintenance.

There was an anonymous complaint related to the maintenance services in the home.

The home was observed to have areas where the vinyl baseboard trim was cracked, peeling and/or chipped and dry wall was damaged above some of these areas. There was an area of floor that was chipped and peeling. Paint was chipped and layered with different paint colours around resident door frames. Drywall was cracked and chipped at wall corners and baseboard heating units were dented, rusting and chipped. There were multiple ceiling tiles discoloured and appeared to be water damaged.

Administrator #100 verified the areas of disrepair and shared the home was without a maintenance person for six months.

The QCC Corp Watford Quality Care Centre Preventative Maintenance policy effective January 2020 stated periodic room checks need to be made for touch up painting, loose vinyl baseboards, etc. Floor tiles and ceiling tiles were to be replaced when broken or stained.

Staff member #130 stated resident #017 and #018 were nervous to walk over the floor tile located in Maple Grove that had a hole in it, stating there was a falling risk for residents and the floor was not safe for the staff either. Staff member #130

verified the floor was in disrepair for almost three years.

The "Maintenance" communication book was a procedure used for remedial maintenance. The Administrator shared that staff would document a maintenance concern, the maintenance person and the Administrator would do a daily walk through and areas of concern were added to the communication book. The maintenance person would check the book daily and cross off those items that have been addressed. There were a number of entries documented in 2019 and in 2020 where the concern was not crossed out as completed and there were no names or dates to indicate if anyone had read or were aware of the concerns. There was no documentation of how the concerns would be addressed or when either. There were numerous entries between January and March 2021 where concerns were logged as part of the communication book with no follow up to indicate if each concern was resolved or pending. The concerns were not crossed out as completed and there was no name or date to indicate if anyone read or was aware of the concern and there was no documentation of how it would be addressed or when.

Maintenance staff member #125 stated they did not do periodic room checks and did not complete a building walk through; but would check the communication binder, complete the work and would follow up on other staff and resident requests in the moment. The Administrator shared that the communication book was ineffective in documenting the remedial maintenance required for follow-up and was recently replaced with a Work Order Request form.

The schedules and procedures in place for remedial maintenance were not completed as per the home's policy or when staff reported a concern. The remedial maintenance procedure was ineffective in communicating, tracking and monitoring those areas of disrepair that required restoration. Residents were also at risk of increased falls and potential injuries due to the uneven flooring.

Sources: staff interviews; review of the Communication Book, work orders, and policies; and observations of the home. [s. 90. (1) (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 by ensuring that as part of the organized program of maintenance services, current schedules and procedures are in place to support remedial maintenance,, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During a night shift and the early morning hours of another night shift, Inspectors observed multiple residents walking through the home and resident #015 was observed walking through the staff service hall. The linen room door located in the main hall and the service hall laundry room door was unlocked and open. Any person could walk through this area in and out of each door where a wall mounted cabinet in the laundry room was unlocked with hazardous chemicals accessible.

Multiple Diversey hazardous cleaning products were accessible and there was a set of keys accessible and hanging inside the laundry room door that unlocked the housekeeping supply room where chemicals were stored.

Registered Nurse #102 verified residents had access to the chemicals when the laundry room door from the service hall and the linen room door was left open and the keys were accessible to anyone and the keys opened the stock room for laundry and housekeeping chemicals. Administrator #100 verified residents walk through the service hall at night and verified that the linen/laundry room doors should remain closed and hazardous substances were to be kept inaccessible to residents at all times.

Sources: resident and home observations, and staff interviews. [s. 91.]

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 by ensuring all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows, the date of the action, time frames for actions to be taken, any follow-up action required, every date on which any response was provided to the complainant, a description of the response and any response made in turn by the complainant.

Resident #017 reported a verbal complaint regarding alleged staff to resident abuse involving resident #019 to Director of Care (DOC) #101. On a separate occasion resident #017 shared a different verbal complaint of alleged staff to resident neglect to a staff member, and that staff member reported the verbal complaint to DOC #101. As per the home's policy, "Watford Quality Care Centre (WQCC) Complaints" effective January 2021, DOC #101 filled out two separate forms titled, "WQCC Client Service Response Form" and the "WQCC Health Services Response and Resolution Form" for each complaint. Each complaint documented the nature of each verbal or written complaint, the date the complaint was received, and the type of action taken to resolve the complaint. However, the DOC did not document the date of the action, timeframes for actions to be taken, any follow-up action required, every date on which any response was provided to the complainant or a description of the response and any response made in turn by the complainant for each complaint.

DOC #101 said the information required as per their policy and the legislation was not documented and should have been. A complete written record ensured complaints and concerns were dealt with appropriately with the staff and residents involved, and the residents' needs were met, and concerns resolved if possible.

The licensee's failure to ensure that each complaint concerning the care of a resident was documented according to legislation presented an increased risk for residents, as it prevented a thorough and accurate record of the residents' concerns and any resolutions.

Sources: Record review of the home's "Complaint" and "Prevention, Elimination and reporting of Abuse" policies, the home's Complaint binder and PAC meeting review, and interviews with management. [s. 101. (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 by ensuring each written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home is dealt with according to legislative requirements,, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies, that was secure and locked, and controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

There was an anonymous complaint related to unsafe storage of medications.

A) Registered Nurse (RN) #105 and Registered Practical Nurse (RPN) #110 were observed at the nursing station with the door to the medication room open and a clear plastic bag could be seen from the hallway containing both brown and white paper bags. RN #105 and RPN #110 verified the medications were non-controlled and controlled drugs delivered from pharmacy every and placed on the floor of the medication room for the night RN to sign them in.

RN #102 verified the brown paper bags from pharmacy were the standing order strip packs for residents and the white paper bags were the controlled substances. RN #102 shared pharmacy delivery of medications occured consistently once a week and the medications were stored on the floor until they arrived for their shift.

The Pharmacy Drug Storage Policy 7.1 for Non-Controlled Substances stated medications must be safely and securely stored in a locked medication room or cabinet immediately upon receipt from the pharmacy. The Pharmacy Drug Storage Policy 7.2 for Controlled Substances stated controlled substances from the pharmacy should arrive in dedicated white bags and must be stored separately in a double-locked area.

The Director of Care (DOC) #101 verified the process for storage of medications delivered from the pharmacy was in the locked medication room and the controlled substances were to be double locked in the medication cart and the night nurse would count them in. With the medication room door open, and the medications stored unlocked and unsecured increased the risk of missing controlled substances.

B) The medication refrigerator inside the medication room was observed with multiple boxes of insulin in clear plastic bags, multiple collected COVID swabs in clear plastic BIOHAZARD bags in the bottom of the fridge, cartons and small bottles of Resource, water jugs, an open container of chocolate pudding and other small food items. RN #105 verified the medication refrigerator was for medications, COVID swabs and urine samples.

The Pharmacy Receiving Medication Policy 6.2 stated refrigerated medications should be stored separately from other items such as food, specimens and

vaccines.

The Public Health Nurse #121 stated the Public Health Ontario (PHO) Checklist for Clinical Office Practice stated there must be a dedicated specimen refrigerator, and that the storage area for specimens must be separate from clean supplies. The Infection Prevention & Control for Clinical Office Practice stated that one fridge should be used for specimens. There was an increased risk to residents of unintentional cross contamination between specimen swabs and other various items stored in the same fridge.

Sources: observations of medication storage areas, relevant pharmacy policies, and staff interviews. [s. 129. (1)]

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 by ensuring drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies, and that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including areas where drugs were stored shall be kept locked at all times, when not in use and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

There was an anonymous complaint related to the unsafe storage of medications in the home kitchen refrigerator.

Registered Nurse (RN) #102 shared that there were medications stored in the kitchen refrigerator. The walk-in refrigerator was located in the kitchen area of the home. There were medications located on the bottom rack labelled for resident #007 and contained medication administration accessories as well. Kitchen staff, nursing and housekeeping staff had access to the kitchen.

The Pharmacy Receiving Medication Policy 6.2 stated medications must be safely and securely stored in a locked medication room or cabinet. The medications were not stored securely and were not restricted to the registered nursing staff who administer the drugs in the home.

The Administrator #100 verified there was a storage problem in the home and that was why the medications were stored in the kitchen refrigerator. The Administrator verified kitchen staff would have access to the medications. The Director of Care #101 shared that although the kitchen was locked, the kitchen refrigerator was not.

Sources: observations of medication storage areas, review relevant pharmacy policies, and staff interviews. [s. 130.]

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 by ensuring all areas where drugs are stored shall be kept locked at all times, when not in use and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator,, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure as part of the organized program of housekeeping, procedures were developed and implemented for cleaning of the home; including floors, windows, contact surfaces (fountain) and wall surfaces.

There was an anonymous complaint related to housekeeping and the unclean shared water fountain used by staff and residents.

The main dining room area had a build up of dirt, debris, hair, food and cobwebs in the grooves along the scalloped wall observed over a period of several days and shifts. In the hallways there were multiple areas where dirt, dust, hair and debris were built up in wall corners, in corners of doorways and along windowsills.

The water fountain located in the service hall was observed for a ring of black and yellow coloured build up around the drain, a buildup of a brown black substance at the spout and base and there appeared to be calcified staining of the basin of

the fountain. The vents at each side of the fountain had a build up of dust and what appeared to be dried fluids.

There were several QCC Corp Watford Quality Care Centre policies that spoke to cleaning floors, windows and walls. Floors were to be dust mopped and wet mopped daily, housekeepers were to wipe off baseboards, wipe down cob webs, sweep dirt to the doorway and pick up with the dustpan and they were to spot check walls and wash where needed. The drinking fountain was to be disinfected. The “Dining Room Cleaning” described a routine to remove any debris and check walls for visible soiling and clean if required.

Housekeeper #131 said, it was their understanding there was a routine for cleaning floors that included mopping after meals, cleaning the floors in common areas like hallways, and wiping down the baseboards and door frames as well. The scalloped wall in the dining room was to be cleaned using a cloth on the floor and vacuumed as needed. The housekeeper shared that the scalloped wall was difficult to clean because of its texture. Windows were wiped as needed and the housekeeper stated they just scraped the residue out, as well as scraping along the door frames. Housekeeper #131 said, the water fountain should be wiped down every day and disinfected on day and evening shifts.

Administrator #100 verified the areas were unclean with a build up evident along the perimeter of the dining room floor, hallway corners and door frames. The Administrator shared that the build up in windowsills should be removed and caulked and the floors along door frames needed to be scraped of dirt and build up. The Administrator verified the water fountain was unclean and placed the fountain out of order. The housekeeping routines were not consistently implemented to ensure floor perimeters, windows, walls and the water fountain were kept clean and sanitary.

Sources: staff interviews; review of the Communication Book, work orders, and policies; and observations of the home. [s. 87. (2) (a)]

Issued on this 11st day of May, 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 SAMANTHA PERRY (740) - (A1)
Inspection No. / No de l'inspection :	2021_797740_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003849-21, 003964-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 11, 2021(A1)
Licensee / Titulaire de permis :	QCC Corp. 3942 West Graham Place, London, ON, N6P-1G3
LTC Home / Foyer de SLD :	Watford Quality Care Centre 344 Victoria Street, Watford, ON, N0M-2S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya McGill

To QCC Corp., 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_797740_0003, CO #001;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with section 5 of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

A) Follow Directive #3 and the applicable guidance documents related to the active screening of all people, including but not limited to, staff and visitors entering the Long-Term Care home.

B) Educate the management team, registered staff and non-registered staff regarding their specific roles and responsibilities related to the active screening of all persons entering and exiting the Long-Term Care home at any time throughout the day, evening and night, as outlined in Directive #3.

C) A written record will be maintained by the home including,
- The content of the materials used to educate staff
- The dates of each education session with an attendance list, including printed names and signatures of all attendees
- The name of the staff member providing the education for staff

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment related to the failure to maintain infection prevention and control

measures specified in Directive #3 and relevant guidance documents, regarding the immediate implementation of active screening of all people, including but not limited to staff and visitors entering the home, to protect residents from COVID-19.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2021_797740_0003 issued on March 04, 2021, with a compliance due date of March 06, 2021.

The licensee was ordered to ensure that they were compliant with s. 5 of the LTCHA.

Specifically, the licensee was ordered to:

- Follow Directive #3 and the applicable guidance documents related to the active screening of all people, including but not limited to, staff and visitors entering the Long-Term Care home.

The home failed to meet CO #001.

The licensee has failed to ensure that the home was a safe and secure environment when all persons, including inspectors #740 and #563 were not actively screened for COVID-19 upon their entrance and exit of the home.

During a night shift inspectors arrived at the home and were greeted by Personal Support Workers (PSW) #114 and #115. The PSWs unlocked the front entrance of the home, inspectors entered and the two PSWs then left the front entrance area without any direction provided to inspectors regarding active screening requirements. Inspectors screened themselves and then spoke with Security Guard (SG) #112 located at the rear entrance of the home. SG #112 said, it was their understanding they were responsible for actively screening all staff and visitors entering the home from the rear entrance and it was the staff's responsibility to actively screen any persons entering the home through the front entrance. Registered Nurse (RN) #102 and #105, and Registered Practical Nurse (RPN) #110 said it was their understanding that during the day anyone entering the home through the front entrance was actively screened by the ward clerk. Registered staff, either an RN or RPN on evenings and the RN on nights were responsible for actively screening all persons entering the front entrance of the home during the evening and night shifts. During the same night shift inspectors exited the home without being screened.

During an additional three separate shifts throughout the inspection, inspectors were not actively screened by registered staff for COVID-19 when entering at the front entrance of the home. Administrator #100 said it was their expectation and registered staff were aware of their responsibility to actively screen any visitors, including inspectors, entering the home through the front entrance. Administrator #100 said that registered staff did not actively screen inspectors upon their entrance and exit of the home consistently and should have. The risk to all residents increased when the licensee failed to actively screen all visitors for COVID-19 when entering and exiting the home.

Based on observations, interviews and record review the licensee has failed to ensure the home was a safe and secure environment when active screening upon entry and exit of the home was not completed for inspectors #563 and #740. The licensee has also failed to comply with CO #001 from Inspection #2021_797740_0003 as they did not follow Directive #3 and all associated guidance documents by the Compliance Due Date (CDD) March 6, 2021.

An order was made by taking the following factors into account:
Severity: All residents of the home were in actual risk of exposure to COVID-19, due to the lack and implementation of active screening for all persons, as per Directive #3.
Scope: The scope of the non-compliance was widespread, as the lack of active screening and actual risk of exposure to COVID-19 had the potential to affect all residents.
Compliance History: One Compliance Order (CO) not complied, was issued to the home related to same section of the legislation in the past 36 months.

Sources: Directive #3 (dated March 30, 2020 and December 09, 2020); MOH guidance documents - COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH) dated April 01, 2020 & COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes dated April 24, 2020; the home's policies and documents pertaining to the active screening of staff and visitors entering the home, observations at the front and back entrance of the home, interviews with registered and non-registered staff, the Director of Care and the Administrator. (740)

May 26, 2021(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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with section 20 of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:
A) Educate the management team, registered staff and non-registered staff related to all reporting requirements specific to their role as per legislative requirements, including but not limited to,
- when registered staff are to report to management and or the Ministry of Long-Term Care (MLTC);
- when non-registered staff are to report to registered staff, management and or the MLTC;
- the criteria for immediate reporting to management and the MLTC and;
- the importance of complying with the home's zero tolerance of abuse and neglect policy.

B) A written record will be maintained by the home including,
- the content of the materials used to educate staff;
- the dates of each education session with an attendance list, including printed names and signatures of all attendees, and;
- the name of the staff member providing the education for staff.

Grounds / Motifs :

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

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, was complied with.

An anonymous complaint received by the Ministry of Long-Term Care (MLTC) reported allegations of neglect related to the personal care of multiple residents.

The "Prevention, Elimination and Reporting of Abuse" policy, effective March 2018 documented, all staff members were and that "neglect" included "staff neglect" whether intentional or not, was also a form of abuse and the same mandatory reporting requirements applied.

Resident #002's clinical records documented an allegation of abuse and staff verified they did not report the allegation to the management team according to the home's, "Prevention, Elimination and Reporting of Abuse" policy.

Administrator #100 and Director of Care (DOC) #101 said, they were not aware of either the anonymous complaint reported to the MLTC or resident #002's allegation of physical abuse. Administrator #100 and DOC #101 said, it was their expectation that all staff members report any suspected or witnessed resident neglect and or resident abuse, immediately to the charge nurse and or directly to management.

Based on observations, interviews and record review the licensee failed to ensure the policy to promote zero tolerance of abuse and neglect of residents, was complied with.

An order was made by taking the following factors into account:
Severity: There was minimal risk to more than one resident related to the home's failure to comply with their policy to promote zero tolerance of abuse and neglect.
Scope: The scope of the non-compliance was patterned, as more than one resident was affected when the licensee failed to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with.
Compliance History: There was no non-compliance issued to the home related to s. 20 of the legislation in the past 36 months.

Sources: The home’s Prevention, Elimination and reporting Abuse policy and interviews with management and staff. (740)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 26, 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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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
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.

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

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

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
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 11st day of May, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SAMANTHA PERRY (740) - (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

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

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