Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2021	2021_868561_0007	021203-20, 021888-20, 024503-20, 013765-21	Complaint

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760 14th Avenue Suite 402 Markham ON L3R 3T7

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

Arbour Creek Long-Term Care Centre
2717 King Street East Hamilton ON L8G 1J3

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

DARIA TRZOS (561), LEAH CURLE (585)

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): August 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, 2021 and September 1, 2 (off-site), 3, 2021.

The following log numbers were inspected during this inspection:
log #021888-20 - related to infection prevention and control, maintenance and pest control,
log #024503-20 - related to multiple care issues,
log #013765-21 - related to medication management.

Complaint log #021203-20 was previously inspected under the inspection #2021_820130_0001, and non-compliance with a voluntary plan of correction (VPC) was issued under s. 44(7) for resident #003.

Critical Incident inspection number 2021_868561_0008 was conducted concurrently with this inspection.

Long Term Care Consultant and Environmental Inspector #120 was also present during this inspection on August 23, 2021.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Director of Care/Infection Prevention and Control lead (CDOC/IPAC), Staff Development/Quality Improvement staff, Environmental Services Manager (ESM), Food Services Manager (FSM), Dietary Aide staff, maintenance staff, manufacturer representative from Diversey, Manager of Call Centre at Prevail, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, laundry staff, residents and families.

During the course of the inspection, the inspector(s) completed an Infection Prevention and Control (IPAC) checklist, cooling requirements, observed provision of care, observed the main kitchen, servery areas, tub rooms, reviewed clinical records, investigation notes, policies and procedures relevant to the inspection and program evaluations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
7 VPC(s)
3 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. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not charged for anything that the regulations provided not to be charged for.

Ontario Regulation 79/10 section 245 paragraph 1 states:
“The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act:
1.Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act”.

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

An anonymous complaint was received related to residents' having to purchase an identified type of a continent product, if they wished to continue to wear it. As per the complainant three residents used to wear this type of product, but since the home switched to a new supplier, they no longer provide them for residents. Families were told that they had to purchase those products if they chose to continue to wear them. Two residents that were identified were interviewed and stated that the home told them they would no longer provide the identified product. One of the resident's substitute decision maker (SDM) was interviewed and stated that the resident switched to a different product because the home would no longer provide the original one. The other resident's SDM stated that since the home switched the supplier, they have been buying the identified product for the resident. Both residents indicated that they did not feel this was right and were upset about this.

The Staff Development/Quality Improvement staff (continence lead) stated that they had switched companies over a year ago and no longer provide the product that these three

residents were wearing prior. They also stated that they were not aware that families were purchasing them.

Sources: clinical record review for residents, including care plans and MDS assessments; Prevail - resident worksheet (list of products by resident); observations; interviews with Staff Development/Quality Improvement staff (continence lead) and other staff; interviews with residents and their SDMs. [s. 91. (1) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents, who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence

and potential to restore function with specific interventions, and that it was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A resident's continence had deteriorated between quarterly assessments in 2020, as indicated in Minimum Data Set (MDS) assessments. Another resident's continence had deteriorated between quarterly assessments in 2021, as indicated in Minimum Data Set (MDS) assessments. Both resident's clinical records were reviewed and they indicated that the residents were not assessed when there was a change in their continence using a clinically appropriate assessment instrument that was specifically designed for this purpose. A third resident's clinical record was reviewed and indicated that they were admitted to the home in 2018, and they did not have a continence assessment completed upon admission. The Staff Development/Quality Improvement staff, who was also the lead for the continence program in the home confirmed that the residents were not assessed when there was a change in their continence or upon admission.

Sources: residents' clinical records, including MDS assessments and the written plan of care; home’s Bowel/Bladder Assessment policy (revised May 2021); interviews with Staff Development/Quality Improvement staff and other staff. [s. 51. (2) (a)]

2. The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs and that promoted resident comfort, ease of use, dignity and good skin integrity.

Interviews with PSWs and registered staff identified that the home has not been providing an identified continence product for residents once they switched to a new company last year. Three residents were identified to be either purchasing this product for themselves or had to switch to a different product that was not equivalent. Two of the residents stated that they used to wear the identified product but about a year ago the home told them that if they wanted to continue to wear that, they would have to purchase it on their own. One of the residents stated that they switched to the product that the home provided which was not equivalent. The other resident's family decided to purchase the identified product as they preferred the original product type. Both residents were upset at the fact that they were told that they needed to purchase these products. A third resident was observed to be wearing a product that was not the identified product. A PSW stated that this resident did not have a family who would be able to purchase this particular product, therefore the resident was switched to a different one.

The Staff Development/Quality Improvement staff (continence lead) was interviewed and stated that they had switched companies over a year ago and instead of the identified product they now provided a different one. They also provided a list of residents and the continence products that were currently being used by residents. This identified product was not on the list as a choice of a product for incontinence.

Residents were not provided a range of continence products based on the assessed needs and that promoted comfort, ease of use and dignity.

Sources: residents' written plans of care, MDS assessments; observations, request for resident change form, Prevail - resident worksheet (list of products by resident); interviews with staff, residents and their SDMs. [s. 51. (2) (h)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that it is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: 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).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15(1)(c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, specifically for the home and equipment.

Flooring

A large section of flooring material running down the centre of most of the dishwasher room was not smooth, tight-fitting, impervious to moisture or easy to clean. The area was comprised of a patch work of individual flooring pieces, with one large piece missing, exposing wood underneath. The licensee was aware of the condition of the flooring but did not have any plans in place to remediate the flooring. The condition of the flooring was not included in the licensee's preventive maintenance procedures.
A depression surrounded by multiple cracked tiles was observed in front of the shower area on the fourth floor. The issue had not be reported to maintenance staff as required by their policies using a computer-based program and maintenance staff had not inspected the condition of the floors in the shower area as their preventive procedures did not include checks of the shower and tub room areas.

Wall/Ceiling Surfaces

The surfaces of the wall next to the dishwasher area hand sink and the wall in the 4th floor servery (behind coffee machine) had cracks, holes and peeling paint and was not smooth or easy to clean. A black substance (mould) was observed growing along the

corner towards the ceiling of the wall in the 4th floor servery near the hand sink. The maintenance staff were not made aware of the issues and dietary staff did not report the issues.

The lower half of a wall next to the ice machine in the main kitchen was covered with a large piece of vinyl or similar material. This material was damaged and bulging in areas. When pressed, the area behind the material was soft and a cockroach dropped down onto the floor. A similar wall material was noted under the windows in the kitchen area, which was loose and not adhered to the drywall underneath. The licensee did not have any plans in place to address the condition of the walls. Wall surfaces were not included in any established schedule of checks or preventive maintenance procedures.

Stained and missing ceiling tiles noted in the housekeeping closet in the main kitchen. Maintenance staff were not aware of the issue. Area was not included on any established schedule of checks or preventive maintenance procedures.

Equipment/Other

A grease trap located under the three-compartment sink in the dishwasher room was not functioning properly. It was identified to need replacement in 2020. According to the Environmental Services Manager (ESM), a quote was first obtained in August 2020 to replace the grease trap. A replacement date was not known at time of inspection.

A window in the fourth-floor shower room was missing window locking hardware. The hardware was observed sitting on the sill. The disrepair was not reported to maintenance staff. Windows were identified on the licensee’s Preventive Maintenance and Systems Schedules for a quarterly inspection but did not include which windows would be checked and exactly what window components would need to be checked.

The two swing entry doors to the first-floor servery area were not in good condition, with a lock set missing on one gate. One swing door with a bankers-type lock was loose and could not close properly without manipulation. Maintenance staff were unaware of the condition of the swing doors and serveries were not identified as an area to check on any preventive maintenance task list or in any preventive maintenance procedure.

Faucets at the three-compartment sink and at the rinse station for the dishwasher were dripping heavily for an unknown period of time. Dietary or kitchen staff did not report the issue and the licensee’s procedures for maintenance checks did not include sinks and

plumbing in the kitchen or dishwasher room. Dishwashers were included on a preventive maintenance schedule for a monthly check (last inspected July 2021) but did not include what specific components to check other than to clean rinse nozzles and lubricate pivot points on the dishwasher doors.

Sources: Interviews with staff and record review (Dishwashers Preventive Maintenance Task (ES E-50-15), Grease Trap Preventive Maintenance Task (ES E-50-25), Preventive Maintenance Systems and Schedules (ES E-05-05), Daily Maintenance Check Form, Food and Nutritional Services Manual – Cleaning Procedures, Arbour Creek Audit Checklist (resident rooms), Maintenance Service Requests (ES E-05-10) [s. 90. (1) (b)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, specifically tubs and the main kitchen dishwasher, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.

A tub on the fourth floor was reported by a PSW to be in disrepair (shower and disinfectant buttons on control panel not functional) for approximately one year and as a result, residents who preferred a bath were given showers instead. During the inspection, the tub was checked, and confirmation was made that the button for the shower wand did not work properly and the disinfectant button could not be tested as the disinfectant for the tub was empty.

According to maintenance records related to the fourth-floor tub, the bathtub buttons not functioning and the shower head in the bathtub in disrepair was first identified and reported by PSW staff on October 21, 2020 and was corrected on November 3, 2020. The same issue re-occurred and was reported by PSW staff on July 24, 2021. According to both the ESM and the maintenance person, the tub manufacturer’s approved technician was contacted several times thereafter to repair the tub but no return contact was made (later confirmed contractor was on vacation). An alternate technician was contacted post inspection conducted on August 23, 2021 and arrangements made to repair the tub by August 29, 2021.

The licensee did not have a preventive maintenance contract with the tub manufacturer to inspect all of their tubs on a regular basis. According to the ESM, the tubs were obsolete and no longer under warranty. No written procedures were developed to have the tubs in the home preventatively checked by a qualified staff member (i.e. maintenance person) in accordance with the manufacturer’s specifications. This included

a monthly check of the shower head, water filters and thermostatic mixing valve and a yearly check of many mechanical and electrical components (for which a qualified person would be necessary). According to the ESM, the preventive maintenance component for their tubs was dependent on PSW staff who were responsible for checking the tubs during use and reporting any issues to maintenance via an internal computer-based reporting program.

A dishwasher in the main kitchen was observed to be heavily coated in hard scale and food debris on the outside and heavy scale on a strainer bucket on the inside. The Food Services Supervisor (FSS) reported that a dietary aide was responsible for cleaning the dishwasher after each meal service and that twice a week, the unit was de-scaled. Dietary aide, who was responsible for de-scaling the dishwasher identified that they used a de-scaler twice a week by pouring the product in the wash water well of the machine and running it several times. The aide did not notice the scale and debris on the sides of the machine and stated that they do not clean the outside of the machine.

A weekly cleaning schedule posted in the kitchen area identified that the dishwasher was to be cleaned after each meal. No specific details were included as to what parts of the machine were to be cleaned (inside and outside, underside of drain boards, etc.). A procedure (ES G-05-05) did not include the dishwasher as part of the list of equipment needed to be cleaned and/or descaled. Based on the amount of scale and debris on the machine and the hardness of the material, daily cleaning, as required by the weekly schedule and the manufacturer’s specifications was not implemented and the procedures were not specific as to what exactly needed to be cleaned and how.

Sources: Interviews with staff and documentation review [Installation, Operation and Care of Hobart Dishwashers, Dietary Aide Weekly Cleaning Schedule, Maintenance Care Task List, Maintenance Service Request forms, Arjo Rhapsody Tub User Manual, Procedure “Delime the Dishwasher” (FNSFS140), Procedure “Contract Specifications – Main Kitchen and Servery” (ES G-05-05)]. [s. 90. (2) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 procedures are developed and implemented to ensure that electrical and non-electrical equipment, are kept in good repair, and maintained and cleaned at a level that meet manufacturer specifications, at a minimum, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

The LTCH did not include in their IPAC program, measures to prevent the transmission of infections by providing staff with a hand hygiene product that had an effective level of sanitization to kill viruses.
A hand hygiene product was distributed within the LTCH for use as a hand sanitizer by health care staff to prevent the transmission of communicable bacteria and viruses. The product was observed to have various expiry dates from May 2018 and December 2020. The product's label identified that it contained 72% of alcohol. According to Public Health Ontario's "Best Practices for Hand Hygiene in All Health Care Settings, April 2014 ", a minimum of 70% is recommended for use in LTCHs. According to the manufacturer, who was contacted on August 16, 2021, the product's effectiveness cannot be guaranteed after the expiry date. Therefore, the LTCH did not ensure that the IPAC program included measures to prevent the transmission of infections by ensuring that hand hygiene products used by staff were used before the manufacturer's expiry date which is a guarantee that the alcohol concentration is at or above 70%.

Sources: home's IPAC Manual; observations of hand sanitizers in the hallways and residents' rooms on second and third floor; interviews with housekeeping staff, representative of the manufacturer of the hand sanitizer and ED. [s. 86. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #5: 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 has failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, including contact surfaces, floors and wall surfaces.

A) On an identified date, prior to lunch meal service, the Clayton servery was observed in an unclean condition. Dry solid and fluid debris was observed in a drawer that contained supplies for meal service. Walls and doors in the servery had notable dried darkened food and fluid debris on them.
The home's Dietary Cleaning Schedule located in the servery did not include a routine and or schedule to clean the observed soiled areas.
The FSM confirmed there was no cleaning schedule for the cleaning of drawers in the servery and walls in the dishwashing area, food production areas and servery areas.

Sources: Clayton servery observation; Dietary Cleaning Schedule; interview with the FSM. [s. 87. (2) (a)]

B) The dishwasher area, serveries, tub rooms and kitchen were equipped with a non-slip flooring material which easily traps dirt and becomes black in colour over time if not cleaned with proper equipment. These floors were observed to be discoloured throughout, especially in the kitchen and dishwasher areas. Water and food debris was noted under the three-compartment sink (where the grease trap is located) and under and behind the dishwasher machine. According to the FSS, the floor had not been deep cleaned in over a year.

According to the ESM, no deep cleaning of the floors had been implemented over the

last year. Reasons provided included lack of adequate floor machines (only one floor machine was available) and staffing levels were affected by COVID-19 pandemic. The ESM stated that a total of three machines were recently available and that they would be returning to a monthly cleaning routine as per their written procedures.

Wall surfaces in the dishwasher area (behind the dishwasher), around garbage containers and hand sinks and walls in the fourth-floor servery and dining room (next to cabinet with hand sink) were visibly soiled. According to cleaning routines, walls behind equipment were required to be wiped down as per cleaning schedule or as required in the kitchen and serveries. The procedures were not implemented.
The housekeeping closet in the main kitchen had a heavily stained mop sink, with stained wall material. The FSS identified that a cleaning procedure for the closet was not developed and was not aware of who should be cleaning the closet.

Sources: Interviews with staff and documentation review (Food and Nutritional Services Manual – Cleaning Procedures, Procedure “Contract Specifications – Main Kitchen and Servery” (ES G-05-05), Dietary Aide Weekly Cleaning Schedule. [s. 87. (2) (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 to ensure that procedures are developed and implemented for cleaning of the home, including, common areas and staff areas, including contact surfaces, floors and wall surfaces, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, the licensee failed to ensure that immediate action was taken to deal with pests.

Although the licensee had a contract with a licensed pest controller to treat cockroaches once per week in the home, daytime sightings of cockroaches continued to be reported by staff in the home. During the inspection, live and dead cockroaches were seen in the main kitchen, dishwash area, first floor servery and fourth floor servery and dining area.

Only three pest control sightings reports were completed by staff of the home to the maintenance department in the last 12 months. However, multiple staff from various departments verbally reported seeing cockroaches over the last year in all areas of the home, specifically resident rooms, tub and shower areas, serveries and kitchen.

Pest control service reports include what treatment was carried out and what conditions were seen during treatment. This included sanitation issues around serveries, dining areas, main kitchen and dish area. The same information was included on each report, every week since October 15, 2019.

Immediate action was not taken with respect to either maintenance or sanitation issues which are part of a preventive pest control program. Poor maintenance and sanitation in the dishwasher and kitchen areas were noted and were contributing factors to the harborage of cockroaches in the home.

Sources: Maintenance Care pest control sightings reports; Terminex service reports; Marquis/Compass Pest Control Policy; interviews staff. [s. 88. (2)]

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 immediate action is taken to deal with pests, to be implemented voluntarily.

WN #7: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

During the inspection, a PSW was observed exiting a resident's room with a medication cup which had a controlled substance in it. The PSW stated that the resident refused it. RPN stated that at times the PSWs would bring the medication to residents' rooms; however, they would be the one to administer it. Interviews with a family member and another PSW indicated that there were times when they administered medications to residents in the past. The DOC confirmed that only registered staff or a physician in the home were to administer medications.

Medications administered by unregulated health professionals poses a risk to residents, increases the risk of medication errors and security of drugs.

Sources: MediSystem polices and procedures; observation of medication pass; interviews with family members and other staff. [s. 131. (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 that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program in relation to resident hand hygiene after meals and at snack times.

The home's policy, “Hand Hygiene and Gloves Use”, indicated that residents' hand hygiene will be performed at a minimum before and after eating and/or drinking.

Several observations of the meal and snack service were made and it was observed that residents' hands were not cleaned not were residents offered encouragement or assistance with cleaning their hands, after the lunch meal service and prior to providing residents with snack. This was also confirmed by PSW staff.

The CDOC/IPAC lead confirmed it was an expectation of staff to offer residents hand hygiene before and after eating as per the policy.

Not offering hand hygiene when indicated increased risk to residents as it served as a mechanism to prevent the transmission of infection.

Sources: home’s Hand Hygiene and Gloves Use policy (revised April 2021); meal and snack observations; interviews with staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participates in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they immediately forwarded a written complaint that had been received concerning the care of a resident to the Director.

A resident's SMD submitted a written complaint related to the care of the resident in 2020 via email. The complaint was not forwarded to the Director immediately. ED confirmed that they had not forwarded the written complaint to the Director immediately after receiving it.

Sources: copies of written complaints from the SDM; home’s Client Service Response Form policy (dated June 2018); interview with the ED. [s. 22. (1)]

Issued on this 22nd day of September, 2021

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

Original report signed by the inspector.

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2021_868561_0007
Log No. / No de registre :	021203-20, 021888-20, 024503-20, 013765-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 21, 2021
Licensee / Titulaire de permis :	Rykka Care Centres GP Inc. 3760 14th Avenue, Suite 402, Markham, ON, L3R-3T7
LTC Home / Foyer de SLD :	Arbour Creek Long-Term Care Centre 2717 King Street East, Hamilton, ON, L8G-1J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula White

To Rykka Care Centres GP Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee must be compliant with s. 91(1)4. of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that all current and former residents since January 1, 2021 to present, will be reimbursed for all costs for the identified continence products, that should have been provided at no charge, while the residents resided in the home.

The plan shall include:
1. Development and implementation of an audit to identify if there were any other residents besides resident #006 that were purchasing the identified product.

2. How the home will refund residents/SDMs that were purchasing the product, for the cost of the usage of continence products provided by resident/ families since January 2021.
In the absence of a receipt from residents/families, the home is to estimate the average usage of the product, per resident, per day and refund the resident/SDM for the incurred cost.

3. The development of a system to ensure that all families that were assessed by the home to require the products are contacted and informed that they will be receiving payment from the home for costs that they incurred for purchasing products while the resident resided in the home.

4. A schedule for reimbursement for the current and former residents/SDM for the full cost of the products used during their length of stay by December 31, 2021.

Please submit the written plan for achieving compliance for inspection #2021_868561_0007 to Daria Trzos, LTC Homes Inspector, MLTC, by email to HSAO.generalmail@ontario.ca by October 8, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was not charged for anything that the regulations provide was not to be charged for.

Ontario Regulation 79/10 section 245 paragraph 1 states:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act:
1.Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".

Section 51(2) of the Regulation under the LTCA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii)

promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident’s type of incontinence”.

An anonymous complaint was received related to residents’ having to purchase an identified type of a continent product, if they wished to continue to wear it. As per the complainant three residents used to wear this type of product, but since the home switched to a new supplier, they no longer provide them for residents. Families were told that they had to purchase those products if they chose to continue to wear them. Two residents that were identified were interviewed and stated that the home told them they would no longer provide the identified product. One of the resident’s substitute decision maker (SDM) was interviewed and stated that the resident switched to a different product because the home would no longer provide the original one. The other resident’s SDM stated that since the home switched the supplier, they have been buying the identified product for the resident. Both residents indicated that they did not feel this was right and were upset about this.

The Staff Development/Quality Improvement staff (continence lead) stated that they had switched companies over a year ago and no longer provide the product that these three residents were wearing prior. They also stated that they were not aware that families were purchasing them.

Sources: clinical record review for residents, including care plans and MDS assessments; Prevail - resident worksheet (list of products by resident); observations; interviews with Staff Development/Quality Improvement staff (continence lead) and other staff; interviews with residents and their SDMs.

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

Severity: a level 2 severity was identified as there was minimal harm, two out of three residents indicated that they were upset that they either had to purchase the product or chose a different product because they could not afford to buy it.

Scope: a level 1 scope was identified, as one resident was identified to be purchasing the product; however, two other residents were switched to different products as they could not pay for the original one.

Compliance history: a level 2 compliance history with previous non-compliance issued, however to a different section.
(561)

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

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. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 51(2)(h).

Specifically, the licensee must:

1. Ensure that residents who used the continence product prior to switching the supplier of continent products, are re-assessed for the appropriate product. Assessment shall be completed along with the resident's or SDM's input. Ensure that a record is kept of the assessment.

2. Ensure that resident #006, #007, #008 and any other resident assessed to be requiring the product are provided the product by the home.

3. Ensure that the plan of care is revised to reflect the residents' incontinence product preference based on the assessed need.

4. Revise the "request for resident change form", to include the identified product as a choice of a continence product.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs and that promoted resident comfort, ease of use, dignity and good skin integrity.

Interviews with PSWs and registered staff identified that the home has not been providing an identified continence product for residents once they switched to a new company last year. Three residents were identified to be either purchasing this product for themselves or had to switch to a different product that was not equivalent. Two of the residents stated that they used to wear the identified product but about a year ago the home told them that if they wanted to continue to wear that, they would have to purchase it on their own. One of the residents stated that they switched to the product that the home provided which was not equivalent. The other resident's family decided to purchase the identified product as they preferred the original product type. Both residents were upset at the fact that they were told that they needed to purchase these products. A third resident was observed to be wearing a product that was not the identified product. A PSW stated that this resident did not have a family who would be able to purchase this particular product, therefore the resident was switched to a

different one.

The Staff Development/Quality Improvement staff (continence lead) was interviewed and stated that they had switched companies over a year ago and instead of the identified product they now provided a different one. They also provided a list of residents and the continence products that were currently being used by residents. This identified product was not on the list as a choice of a product for incontinence.

Residents were not provided a range of continence products based on the assessed needs and that promoted comfort, ease of use and dignity.

Sources: residents' written plans of care, MDS assessments; observations, request for resident change form, Prevail - resident worksheet (list of products by resident); interviews with staff, residents and their SDMs.

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

Severity: a level 2 severity was identified as residents were upset and did not feel it was right that they were asked to pay for the incontinence product.

Scope: Although only one family was identified as purchasing the product, there was another resident that chose to go with a different product because they did not want to pay for the original one.

Compliance history: a level 2 compliance history with previous non-compliance issued, however to a different section. (561)

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

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. 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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must be compliant with s. 90(1)(b) of the O. Reg 79/10.

Specifically, the licensee shall complete the following:

1. Develop written preventive maintenance procedures and a schedule for the home, which includes but is not limited to surfaces, materials and fixtures that comprise the building such as doors, walls, floors, ceilings, sinks, plumbing fixtures, roof, baseboards, millwork, lighting fixtures, counters, cabinets, vanities, hand rails, mirrors, windows, grab bars, grilles/vents.

2. The written preventive maintenance schedule and procedures must include all areas of the home, including areas such as serveries, dining rooms, soiled and clean utility rooms, kitchen, dishwash room, housekeeping closets, staff change areas, public and staff washrooms, storage rooms, tub and shower rooms and offices.

3. An audit shall be conducted of all serveries, tub/shower rooms, shared or common washrooms, utility rooms, dishwash area and kitchen at a minimum. The audit results shall be documented as to date completed, name of person who completed the audit and conditions identified (if any) including any required follow up actions.

4. The flooring, grease trap, ceiling, sink faucets and walls in the main kitchen/dishwash area, both swing doors in the first-floor servery and the walls in the fourth-floor servery are repaired where identified.

5. Repair the window lock in the fourth floor shower room, followed by an audit of all windows in the home for condition and the audit results documented as to date completed, name of person who completed the audit and conditions identified (if any) including any required follow up actions.

Grounds / Motifs :

1. As part of the organized program of maintenance services under clause 15(1)(c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, specifically for the home and equipment.

Flooring

A large section of flooring material running down the centre of most of the dishwasher room was not smooth, tight-fitting, impervious to moisture or easy to clean. The area was comprised of a patch work of individual flooring pieces, with one large piece missing, exposing wood underneath. The licensee was aware of the condition of the flooring but did not have any plans in place to remediate the flooring. The condition of the flooring was not included in the licensee's preventive maintenance procedures.
A depression surrounded by multiple cracked tiles was observed in front of the shower area on the fourth floor. The issue had not be reported to maintenance staff as required by their policies using a computer-based program and maintenance staff had not inspected the condition of the floors in the shower area as their preventive procedures did not include checks of the shower and tub room areas.

Wall/Ceiling Surfaces

The surfaces of the wall next to the dishwasher area hand sink and the wall in the 4th floor servery (behind coffee machine) had cracks, holes and peeling paint and was not smooth or easy to clean. A black substance (mould) was observed growing along the corner towards the ceiling of the wall in the 4th floor servery near the hand sink. The maintenance staff were not made aware of the issues and dietary staff did not report the issues.

The lower half of a wall next to the ice machine in the main kitchen was covered with a large piece of vinyl or similar material. This material was damaged and bulging in areas. When pressed, the area behind the material was soft and a cockroach dropped down onto the floor. A similar wall material was noted under the windows in the kitchen area, which was loose and not adhered to the drywall underneath. The licensee did not have any plans in place to address the condition of the walls. Wall surfaces were not included in any established schedule of checks or preventive maintenance procedures.

Stained and missing ceiling tiles noted in the housekeeping closet in the main kitchen. Maintenance staff were not aware of the issue. Area was not included on any established schedule of checks or preventive maintenance procedures.

Equipment/Other

A grease trap located under the three-compartment sink in the dishwasher room was not functioning properly. It was identified to need replacement in 2020. According to the ESM, a quote was first obtained in August 2020 to replace the grease trap. A replacement date was not known at time of inspection.

A window in the fourth-floor shower room was missing window locking hardware. The hardware was observed sitting on the sill. The disrepair was not reported to maintenance staff. Windows were identified on the licensee's Preventive Maintenance and Systems Schedules for a quarterly inspection but did not include which windows would be checked and exactly what window components would need to be checked.

The two swing entry doors to the first-floor servery area were not in good condition, with a lock set missing on one gate. One swing door with a bankers-type lock was loose and could not close properly without manipulation. Maintenance staff were unaware of the condition of the swing doors and serveries were not identified as an area to check on any preventive maintenance task list or in any preventive maintenance procedure.

Faucets at the three-compartment sink and at the rinse station for the dishwasher were dripping heavily for an unknown period of time. Dietary or kitchen staff did not report the issue and the licensee's procedures for maintenance checks did not include sinks and plumbing in the kitchen or dishwasher room. Dishwashers were included on a preventive maintenance schedule for a monthly check (last inspected July 2021) but did not include what specific components to check other than to clean rinse nozzles and lubricate pivot points on the dishwasher doors.

Sources: Interviews with staff and record review (Dishwashers Preventive Maintenance Task (ES E-50-15), Grease Trap Preventive Maintenance Task (ES E-50-25), Preventive Maintenance Systems and Schedules (ES E-05-05), Daily Maintenance Check Form, Food and Nutritional Services Manual – Cleaning Procedures, Arbour Creek Audit Checklist (resident rooms), Maintenance Service Requests (ES E-05-10)

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

Severity: a level 2 severity was identified as there was minimal harm identified related to the disrepair of the areas and equipment identified.

Scope: a pattern was identified in relation to not having preventative maintenance procedures and schedules for identified areas and equipment in the home.

Compliance history: a level 2 compliance history with previous non-compliance issued, however to a different section. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of September, 2021

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Daria Trzos

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