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
Apr 20, 2020	2020_788721_0005 (A1)	000780-20, 002194-20	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derry Crest Drive MISSISSAUGA ON L5W 0G5

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

Chartwell Royal Oak Long Term Care Residence
1750 Division Road North KINGSVILLE ON N9Y 4G7

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

Amended by MEAGAN MCGREGOR (721) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Due Date (CDD) changed to June 30, 2020.

Issued on this 20th day of April, 2020 (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

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

Amended by MEAGAN MCGREGOR (721) - (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): February 11, 12, 13 and 14, 2020.

The following Complaint intakes were completed within this inspection:

Log #000780-20/IL-73654-LO related to concerns of short staffing; and

Log #002194-20/IL-74241-LO related to concerns of short staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), an Assistant Director of Care (ADOC), a Corporate Consultant, a Social Worker, a Scheduling Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and visitors.

The Inspectors also observed staffing levels in the home and the care provided to residents, reviewed clinical records and plans of care for the identified residents and reviewed the home's staffing plans, staff rosters, and staff schedules.

This inspection was conducted concurrently with Critical Incident System (CIS) Inspection #2020_788721_0006.

Inspector Deb Churcher #670 was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Sufficient Staffing

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, and included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

The Ministry of Long-Term Care (MLTC) received two complaints, which included concerns related to insufficient staffing in the home and residents bathing, transferring, toileting and continence care needs not being met. The complainants stated that the regular staffing mix in the home was four PSWs and one RPN for each neighbourhood on day and evening shifts and that the home was regularly operating below this staffing level on weekend and evening shifts. They further stated that no baths were provided and several residents were not transferred, toileted or changed on the evening shift on a specific date, because there was only one staff member working on each neighbourhood.

On a specific date Inspector #721 spoke with a residents' family member who stated they were in the home on the evening shift on two specific dates and

observed that the home was extremely short on staff and residents were not getting the care that they required on these shifts.

On a specific date, when asked if the home had a staffing plan that outlined the expected staffing mix at full complement and set out the organization and scheduling of staff shifts, DOC #101 stated they didn't have this information and that the expectation was that the spaces on the staff schedules were as full as possible.

The home's PSW and registered staff schedules were reviewed during a specific 54 date period and indicated the following:

Planned staffing level for PSWs on day shift was four PSWs on each of the five neighbourhoods. The number of shifts worked were below full complement of 20 PSWs on the following number of days during this 54 date period:
- Short one PSW on five specific dates.
- Short two PSWs on eight specific dates.
- Short three PSWs on seven specific dates.
- Short four PSWs on seven specific dates.
- Short five PSWs on four specific dates.
- Short six PSWs on three specific dates.
- Short seven PSWs on seven specific dates.
- Short eight PSWs on seven specific dates.
- Short nine PSWs on two specific dates.

Planned staffing level for RPNs on day shift was one RPN on each of the five neighbourhoods. The number of shifts worked were below full complement of five RPNs on the following number of days during this 54 date period:
- Short one RPN on nine specific dates.
- Short two RPNs on one specific date.

Planned staffing level for PSWs on evening shift was four PSWs on each of the five neighbourhoods. The number of shifts worked were below full complement of 20 PSWs on the following number of evenings during this 54 date period:
- Short one PSW on two specific dates.
- Short three PSWs on six specific dates.
- Short four PSWs on six specific dates.
- Short five PSWs on four specific dates.
- Short six PSWs on six specific dates.

- Short seven PSWs on three specific dates.
- Short eight PSWs on four specific dates.
- Short nine PSWs on seven specific dates.
- Short 10 PSWs on eight specific dates.
- Short 11 PSWs on five specific dates.
- Short 12 PSWs on one specific date.
- Short 15 PSWs on one specific date.

Planned staffing level for RPNs on evening shift was one RPN on each of the five neighbourhoods. The number of shifts worked were below full complement of five RPNs on the following number of evenings during this 54 date period:
- Short one RPN on seven specific dates.
- Short two RPNs on three specific dates.

Planned staffing level for PSWs on night shift was two PSWs each on Mulberry, Magnolia and Oak neighbourhoods and one PSW each on Blue Spruce and Copper Beech neighbourhoods. The number of shifts worked were below full complement of eight PSWs on the following number of nights during this 54 date period:
- Short one PSW on 13 specific dates.
- Short two PSWs on 18 specific dates.
- Short three PSWs on six specific dates.
- Short four PSWs on one specific date.

Planned staffing level for RPNs on night shift was one RPN shared between Mulberry and Blue Spruce neighbourhoods and one RPN shared between Magnolia and Copper Beech neighbourhoods. The number of shifts worked were below full complement of two RPNs on the following number of nights during this 54 date period:
- Short one RPN on three specific dates.

Inspectors observed that the home was not at full complement of PSW staff on the following shifts:
- Evening shift was short one PSW on Mulberry neighbourhood and one PSW on Oak neighbourhood on a specific date.
- Day shift was short one PSW on Magnolia neighbourhood on a specific date.

A review of the home’s documentation titled "PSW Staff Working Short Directive" stated in part the following:

- When there remains less staff then the PSW staff complement the Charge RN was to be informed and immediately initiate the working short directive by communicating to the RPN, who will start the PSW Reassignment Resident Care worksheet and redirect the PSW staff of the change in assignments. The directive gives general direction and if circumstances require, the Charge RN may differ from it to ensure best care for the residents.
- Reassigned staff will provide all aspects of resident care per care plan, including scheduled baths. If scheduled baths are not able to be done then it's reported to the RPN, missed bath list is initiated on 24 hour report, and bath rescheduled to next shift or following day after communicating with the resident.
- When working short PSW job responsibilities include am/hs care, baths, and providing snacks to their assigned residents as per plan.

Working Short Day/Evening Shift Directive:
- One PSW short on one neighbourhood: do not pull, resident assignments are re-distributed within the neighbourhood.
- Two PSWs short on one neighbourhood: pull a part time (PT) PSW from adjacent neighbourhood, if no PT, pull Hall four from adjacent neighbourhood and resident reassignments re-distributed.
- Three PSWs short on one neighbourhood: pull a PT PSW from a neighbourhood that is not short.
- More than three PSWs short building wide: redistribute PSWs to ensure that each neighbourhood has at least three PSWs. Attempt to maintain continuity of care as much as possible.
- Six or more PSWs short building wide: The short neighbourhood will combine with the adjoining neighbourhood to form one large neighbourhood with reallocated resident assignments between five PSWs. See reassigned resident care working short form to direct staff.

Working Short Night Shift Directive:
- It is preferred that the night shift does not work short.
- One PSW short on one neighbourhood: The PSWs will cover each other breaks ensuring that staff are available on the floor to meet the resident needs. PSW position may need to be covered by the registered staff for short periods of time to ensure proper monitoring for safety of the residents. If for some reason the midnight PSW is unable to get up their assigned resident, they are to complete am care and assist another resident with getting up for the day.

A review of the home's documentation titled "PSW Working Short Reassignment Roster - Days/Evenings", last updated June 18, 2018, included direction for reassignment of resident care in scenarios when short one PSW on a

neighbourhood and when short six or more PSWs building wide with five PSWs between two neighbourhoods. The form indicated break times, hall sections, resident rooms, baths and other notable tasks, and additional duties assigned to each staff member.

A review of the home's documentation titled "RPN Working Short Directive" stated in part the following:
- The Charge RN will communicate the RPN shortage to all RPNs as soon as possible via the roster or personal notification and will inform PSWs on short neighbourhood to contact the Charge RN with any concerns.
- If possible, a registered staff member scheduled in another role should work on that neighbourhood to ensure a registered staff presence for situational management.
Working Short Directive:
- The RPNs on the other neighbourhoods will do medication pass and half of medication rounds on the short neighbourhood as per rotation list kept in the Charge RN binder. Odd hour medications are to be given by the RN unless re-delegated due to situational management.

During an interview on a specific date PSW #105 told inspector #730 that they had concerns related to staffing levels in the home. They said that short staffing was more of an issue on weekends and evening shifts and they noticed staffing levels had declined in the few months prior. When asked if being short staffed effected resident care, PSW #105 said that baths were often cancelled as a result of short staffing. They said that it was typically residents who could not speak for themselves who missed baths.

During an interview on a specific date PSW #106 said that staffing levels in the home had declined over the last three months on all days of the week. They said that there were typically four PSWs on each neighbourhood, but at times there might only be one or two. They stated that they were aware of how PSW responsibilities were redistributed when there were three PSWs working on one neighbourhood and two PSWs on the adjacent neighbourhood, but not when there were fewer PSWs than this. PSW #106 said that even though they were aware two staff were required to transfer residents with lifts, there had been times they had transferred residents with lifts independently because there was no other staff available to assist them due to low staffing levels.

During an interview on a specific date, when asked if they were able to provide

residents with the care that they required on a consistent basis with the current staffing mix in the home, PSW #112 said they were able to provide the required care when at full complement but not if they were short. They stated that they received direction from the nurse in situations when there was not a full complement of PSW staff working in the home. When asked if there had been any shifts where they were not able to provide residents with the care that they required due to short staffing, PSW #112 stated every day. PSW #112 continued to state that when working short resident care needs were prioritized, with toileting and answering call bells being the highest priority. PSW #112 said baths were usually missed when working short and they were aware baths had been missed that day due to short staffing.

During interviews on two specific dates, when asked how they would know what care a resident required related to bathing, transferring, toileting and continence care, PSW #104 stated this would be indicated on the residents' care plan and scheduled baths would be indicated on the bath list at the nursing station. PSW #104 said they would document the care they provided to residents during their shift under tasks on PointofCare (POC). PSW #104 said that residents were to receive two baths per week. They said that if a resident missed a bath it would be documented as Not Applicable (NA) on POC. They stated missed baths were typically also documented on the 24 hour report at the nursing station. They said that made up baths would also be documented on POC under the "Bathing" task scheduled as needed (PRN). When asked how many PSW staff were scheduled on each neighbourhood on day and evening shifts, PSW #104 stated there should be four PSWs per neighbourhood and that they were often working with less than four and typically worked with only two PSWs on a neighbourhood on weekends. When asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW staff working in the home, PSW #104 stated they were used to working short and had just figured out on their own how to get stuff done. They said that when working short they were not able to provide residents with the level of care they would like to be able to give and baths don't get done. PSW #104 stated on the evening shift of the date identified in the complaint, they worked the entire shift as the only staff member on a neighbourhood and were responsible for providing care to all residents on that neighbourhood by themselves. When asked if they were able to provide residents on that neighbourhood with the care they required on this identified date, PSW #104 said they were unable to bath any residents and could not transfer, toilet or change any residents requiring a second staff member for assistance, resulting in five or six residents being left in their chairs and without toileting or continence

care the entire shift.

During an interview on a specific date PSW #102 stated they worked the evening shift as the only PSW on a specific neighbourhood on the date identified in the complaint and received help with completing resident care from a registered staff member. They said that when PSW staff were unable to provide required care for a resident they would document “NA” or would not document anything under tasks on POC. PSW #102 stated that residents were regularly missing baths due to short staffing and it would be documented on the 24 hour report at the nursing station when a resident missed their bath.

During an interview on a specific date PSW #107 stated they worked the evening shift as the only staff member on a specific neighbourhood on the date identified in the complaint and were responsible for providing care to all residents on this neighbourhood themselves.

During an interview on a specific date PSW #114 told inspector #730 that they worked the evening shift on the date identified in the complaint. They said that they were the only PSW between two specific neighbourhoods on that shift and were frustrated with the lack of communication and direction about what was happening. PSW #114 stated that they knew there were at least five residents that were not toileted or changed on one of these neighbourhoods that evening.

During an interview on a specific date RPN #111 said it was normal for care not to be provided on weekend and evening shifts due to short staffing. They said that as a result of short staffing, baths often weren’t completed and that sometimes night shift staff would come in and find residents still up because evening shift couldn’t transfer them into bed. RPN #111 stated that short staffing was not as much of an issue with registered staff as they were often asked to work overtime hours and management would come in to provide coverage if needed. When asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW or RPN staff working in the home, RPN #111 said that years ago they were provided a back-up plan for what to do when short staffed but the plan didn’t tell didn't tell them what to do in situations with only one staff member on each neighbourhood. They stated that when a neighbourhood was short an RPN from another neighbourhood would come complete the medication pass on the short neighbourhood and there would be no RPN on the neighbourhood the remainder of the shift.

During an interview on a specific date, when asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW staff working in the home, RPN #103 stated there was a protocol to follow for when there were five PSWs working between two adjacent neighbourhoods and they otherwise made the plan up on their own because there was no plan for when there were fewer than this. RPN #103 stated there were no PSW staff and they were the only staff member working on a specific neighbourhood on the evening shift on the date identified in the complaint. RPN #103 continued to state that another neighbourhood was short an RPN on this shift and at one point they had to leave their assigned neighbourhood to administer medications on this neighbourhood, at which time the Administrator and DOC came to watch over their neighbourhood. When asked if residents were provided with the care that they required on this shift, RPN #103 stated that with the Administrators assistance they were able to provide some care for residents, but baths were not completed and some residents were not transferred to bed or toileted and this care was passed to the oncoming night shift.

It was identified through staff interviews and observations conducted throughout the course of the inspection that residents #001, #002, #003, #004, #005, #007 and #010 had specific care needs and that when staffing levels were not at full complement some of these care needs were not being met.

A review of resident #001's Care Plan in PointClickCare (PCC) showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #001 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 31 scheduled occurrences in a specific 54 date period.

A review of resident #001’s Progress Notes in PCC showed documentation from the evening shift on a specific date stating that resident #001 missed a scheduled bath the day prior and staff were unable to complete the bath this shift.

A review of resident #002's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident

#002 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 28 scheduled occurrences in a specific 54 date period.

A review of resident #003's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #003 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 40 scheduled occurrences in a specific 54 date period.

A review of resident #003’s Progress Notes in PCC showed documentation from three specific dates stating that resident #003 missed their bath.

A review of resident #004's Care Plan in PCC showed specific interventions related to their transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #004 showed tasks related to transferring, toileting and continence care that were not documented on 64 scheduled occurrences in a specific 54 date period.

During an interview on a specific date, resident #004 told inspector #730 that they had concerns related to the staffing levels in the home. They said that there was only one PSW staff on the neighbourhood when there should have been four on a recent date. They said that they brought their concerns forward to the home’s Administrator but felt that their concerns were not addressed. The resident stated that often residents have to go to bed later than they would like as there are not enough staff to transfer them to bed. Regarding bathing, resident #004 said that they have complained numerous times to management that they did not receive their bath at the scheduled time and felt that they only received the care they requested after a complaint was made.

During an interview with a PSW they said they provided resident #004 with specific care related to transferring on the evening shift of the date identified in the complaint, but did not document any of the care provided to them.

A review of resident #005's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #005 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 51 scheduled occurrences in a specific 54 date period.

During an interview with a PSW they said that resident #005 required specific interventions related to toileting and transferring. The PSW said they were working alone on resident #005’s neighbourhood on the date identified in the complaint and that this resident did not receive the required care related to their transferring and toileting needs on this shift.

A review of resident #007's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #007 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 34 scheduled occurrences in a specific 54 date period.

A review of resident #007’s Progress Notes in PCC showed documentation from a specific date stating that their bath was not completed that shift.

A review of resident #010's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled “Documentation Survey Report v2” for resident #010 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as “NA” on 115 scheduled occurrences in a specific 54 date period.

On a specific date and time Inspector #721 observed resident #010 requesting specific interventions related to continence care and being told by staff they would have to wait to receive this care as there were not enough staff members available to provide the care. Inspector #721 spoke with resident #010 later this day and they stated they required specific interventions related to continence care and would notify staff when they required this care. Resident #010 said they had waited approximately 15 minutes to receive the specific continence care interventions that day, but some days they had to wait over an hour to receive this

care.

During an interview on a specific date, when asked what the expected PSW and RPN staffing levels were in the home, Administrator #100 stated the optimal staffing level was 20 PSWs and five RPNs on each neighbourhood on day and evening shifts, and eight PSWs and two RPNs on night shifts. When asked how it was determined this staffing mix was consistent with meeting the residents' assessed care and safety needs, Administrator #100 stated the expected staffing levels were established before they started working in the home and they were confident that residents care needs were being met with the full complement of staff. When asked how the home evaluated whether residents care and safety needs were being met, they stated the nursing department would review care being provided and identify gaps in care on a daily basis. Administrator #100 said they were aware there were shifts during the identified 54 date period when the home was not at full complement of PSW staff due to staff calling in and not being able to fill shifts. When asked if the home had a back-up plan that addressed situations when there was only one staff member working in a neighbourhood, Administrator #100 stated they wouldn't necessarily plan for that type of deep crisis and hope it doesn't happen. When asked if they felt the back-up plan effectively met the care needs of the residents in situations where the home was not at full complement of staff, Administrator #100 stated they thought staff were providing safe care to residents but not the same level of care as when they were at full complement. When asked why there were so many unfilled PSW and RPN shifts on the staff schedules during the identified 54 date period, Administrator #100 stated they had tried to fill the shifts by calling staff in and were not able to as they had recently lost several PT PSW's from their roster. They continued to state that the home was actively recruiting new staff to their roster and had started scheduling agency PSW staff in a specific month to ensure PSW staffing levels were at full complement until they could recruit enough staff to adequately fill these shifts. When asked if they had received any complaints related to the care that was provided to residents during the identified time period when the home was short staffed, Administrator #100 stated they had not received any formal complaints but that concerns had been raised over staffing levels and they had followed up to rectify each concern when care wasn't met.

The licensee failed to ensure that the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs for PSW staff on 50 of 54 day shifts, 53 of 54 evening shifts and 38 of 54 night shifts, and for RPN staff on 10 of 54 day shifts, 10 of 54 evening shifts and three of 54 night

shifts reviewed, and included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work and there are less than five PSWs between two neighbourhoods on a shift. [s. 31. (3)]

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

Issued on this 20th day of April, 2020 (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 MEAGAN MCGREGOR (721) - (A1)
Inspection No. / No de l'inspection :	2020_788721_0005 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000780-20, 002194-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 20, 2020(A1)
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derry Crest Drive, MISSISSAUGA, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Royal Oak Long Term Care Residence 1750 Division Road North, KINGSVILLE, ON, N9Y-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nicole Ross

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l’inspecteur

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To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s 31 (3).

Specifically the licensee must:

a) Ensure that residents #002, #003, #005, #007 and #010 and any other resident is bathed at a minimum twice a week by the method of their choice and that bathing is documented.
b) Ensure that residents #002, #003, #004, #005, #007 and #010 and any other resident is provided with the care and assistance required as outlined in their plan of care related to transferring, toileting and continence care.
c) Review and revise the home's written staffing plan, including the back-up plan that addresses situations when staff cannot come to work, to ensure it meets the assessed care and safety needs of residents. If the home plans to utilize agency staff to fill vacant shifts, the use of agency staff must be addressed in the written staffing plan. The home must keep a documented record of this review, including the date of the review, who participated in the review and a summary of any changes made to the staffing plan.
d) Training shall be provided to the home's leadership team, including the Administrator, Director of Care (DOC) and Assistant Directors of Care (ADOCs), all scheduling clerks, all Registered Nurses (RNs), all Registered Practical Nurses (RPNs) and all Personal Support Workers (PSWs) on the revised staffing plan, specific but not limited to the back-up plan that addresses situations when staff cannot come to work. The home must keep a documented record of the education provided, including the materials that were reviewed, and the dates of the training.
e) Ensure the revised written staffing plan, including the back-up plan that addresses situations when staff cannot come to work, is fully implemented and complied with.
f) Develop and implement a process in the home for the leadership team to monitor and review variances in PSW and RPN shifts from the written staffing plan, at least monthly. The home must keep a documented record of this process and the monthly review.
g) Develop and implement a process in the home for the leadership team to monitor and evaluate whether the written staffing plan, including the back-up plan, is meeting the assessed care and safety needs of the residents, at least monthly. The home must keep a documented record of this process and monthly evaluations.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, and included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

The Ministry of Long-Term Care (MLTC) received two complaints, which included concerns related to insufficient staffing in the home and residents bathing, transferring, toileting and continence care needs not being met. The complainants stated that the regular staffing mix in the home was four PSWs and one RPN for each neighbourhood on day and evening shifts and that the home was regularly operating below this staffing level on weekend and evening shifts. They further stated that no baths were provided and several residents were not transferred, toileted or changed on the evening shift on a specific date, because there was only one staff member working on each neighbourhood.

On a specific date Inspector #721 spoke with a residents' family member who stated they were in the home on the evening shift on two specific dates and observed that the home was extremely short on staff and residents were not getting the care that they required on these shifts.

On a specific date, when asked if the home had a staffing plan that outlined the expected staffing mix at full complement and set out the organization and scheduling of staff shifts, DOC #101 stated they didn't have this information and that the expectation was that the spaces on the staff schedules were as full as possible.

The home's PSW and registered staff schedules were reviewed during a specific 54 date period and indicated the following:

Planned staffing level for PSWs on day shift was four PSWs on each of the five neighbourhoods. The number of shifts worked were below full complement of 20 PSWs on the following number of days during this 54 date period:
- Short one PSW on five specific dates.
- Short two PSWs on eight specific dates.
- Short three PSWs on seven specific dates.
- Short four PSWs on seven specific dates.

- Short five PSWs on four specific dates.
- Short six PSWs on three specific dates.
- Short seven PSWs on seven specific dates.
- Short eight PSWs on seven specific dates.
- Short nine PSWs on two specific dates.

Planned staffing level for RPNs on day shift was one RPN on each of the five neighbourhoods. The number of shifts worked were below full complement of five RPNs on the following number of days during this 54 date period:
- Short one RPN on nine specific dates.
- Short two RPNs on one specific date.

Planned staffing level for PSWs on evening shift was four PSWs on each of the five neighbourhoods. The number of shifts worked were below full complement of 20 PSWs on the following number of evenings during this 54 date period:
- Short one PSW on two specific dates.
- Short three PSWs on six specific dates.
- Short four PSWs on six specific dates.
- Short five PSWs on four specific dates.
- Short six PSWs on six specific dates.
- Short seven PSWs on three specific dates.
- Short eight PSWs on four specific dates.
- Short nine PSWs on seven specific dates.
- Short 10 PSWs on eight specific dates.
- Short 11 PSWs on five specific dates.
- Short 12 PSWs on one specific date.
- Short 15 PSWs on one specific date.

Planned staffing level for RPNs on evening shift was one RPN on each of the five neighbourhoods. The number of shifts worked were below full complement of five RPNs on the following number of evenings during this 54 date period:
- Short one RPN on seven specific dates.
- Short two RPNs on three specific dates.

Planned staffing level for PSWs on night shift was two PSWs each on Mulberry, Magnolia and Oak neighbourhoods and one PSW each on Blue Spruce and Copper Beech neighbourhoods. The number of shifts worked were below full complement of

eight PSWs on the following number of nights during this 54 date period:
- Short one PSW on 13 specific dates.
- Short two PSWs on 18 specific dates.
- Short three PSWs on six specific dates.
- Short four PSWs on one specific date.

Planned staffing level for RPNs on night shift was one RPN shared between Mulberry and Blue Spruce neighbourhoods and one RPN shared between Magnolia and Copper Beech neighbourhoods. The number of shifts worked were below full complement of two RPNs on the following number of nights during this 54 date period:
- Short one RPN on three specific dates.

Inspectors observed that the home was not at full complement of PSW staff on the following shifts:
- Evening shift was short one PSW on Mulberry neighbourhood and one PSW on Oak neighbourhood on a specific date.
- Day shift was short one PSW on Magnolia neighbourhood on a specific date.

A review of the home's documentation titled "PSW Staff Working Short Directive" stated in part the following:
- When there remains less staff then the PSW staff complement the Charge RN was to be informed and immediately initiate the working short directive by communicating to the RPN, who will start the PSW Reassignment Resident Care worksheet and redirect the PSW staff of the change in assignments. The directive gives general direction and if circumstances require, the Charge RN may differ from it to ensure best care for the residents.
- Reassigned staff will provide all aspects of resident care per care plan, including scheduled baths. If scheduled baths are not able to be done then it's reported to the RPN, missed bath list is initiated on 24 hour report, and bath rescheduled to next shift or following day after communicating with the resident.
- When working short PSW job responsibilities include am/hs care, baths, and providing snacks to their assigned residents as per plan.
Working Short Day/Evening Shift Directive:
- One PSW short on one neighbourhood: do not pull, resident assignments are re-distributed within the neighbourhood.
- Two PSWs short on one neighbourhood: pull a part time (PT) PSW from adjacent

neighbourhood, if no PT, pull Hall four from adjacent neighbourhood and resident reassignments re-distributed.
- Three PSWs short on one neighbourhood: pull a PT PSW from a neighbourhood that is not short.
- More than three PSWs short building wide: redistribute PSWs to ensure that each neighbourhood has at least three PSWs. Attempt to maintain continuity of care as much as possible.
- Six or more PSWs short building wide: The short neighbourhood will combine with the adjoining neighbourhood to form one large neighbourhood with reallocated resident assignments between five PSWs. See reassigned resident care working short form to direct staff.
Working Short Night Shift Directive:
- It is preferred that the night shift does not work short.
- One PSW short on one neighbourhood: The PSWs will cover each other breaks ensuring that staff are available on the floor to meet the resident needs. PSW position may need to be covered by the registered staff for short periods of time to ensure proper monitoring for safety of the residents. If for some reason the midnight PSW is unable to get up their assigned resident, they are to complete am care and assist another resident with getting up for the day.

A review of the home's documentation titled "PSW Working Short Reassignment Roster - Days/Evenings", last updated June 18, 2018, included direction for reassignment of resident care in scenarios when short one PSW on a neighbourhood and when short six or more PSWs building wide with five PSWs between two neighbourhoods. The form indicated break times, hall sections, resident rooms, baths and other notable tasks, and additional duties assigned to each staff member.

A review of the home's documentation titled "RPN Working Short Directive" stated in part the following:
- The Charge RN will communicate the RPN shortage to all RPNs as soon as possible via the roster or personal notification and will inform PSWs on short neighbourhood to contact the Charge RN with any concerns.
- If possible, a registered staff member scheduled in another role should work on that neighbourhood to ensure a registered staff presence for situational management.
Working Short Directive:
- The RPNs on the other neighbourhoods will do medication pass and half of medication rounds on the short neighbourhood as per rotation list kept in the Charge

RN binder. Odd hour medications are to be given by the RN unless re-delegated due to situational management.

During an interview on a specific date PSW #105 told inspector #730 that they had concerns related to staffing levels in the home. They said that short staffing was more of an issue on weekends and evening shifts and they noticed staffing levels had declined in the few months prior. When asked if being short staffed effected resident care, PSW #105 said that baths were often cancelled as a result of short staffing. They said that it was typically residents who could not speak for themselves who missed baths.

During an interview on a specific date PSW #106 said that staffing levels in the home had declined over the last three months on all days of the week. They said that there were typically four PSWs on each neighbourhood, but at times there might only be one or two. They stated that they were aware of how PSW responsibilities were redistributed when there were three PSWs working on one neighbourhood and two PSWs on the adjacent neighbourhood, but not when there were fewer PSWs than this. PSW #106 said that even though they were aware two staff were required to transfer residents with lifts, there had been times they had transferred residents with lifts independently because there was no other staff available to assist them due to low staffing levels.

During an interview on a specific date, when asked if they were able to provide residents with the care that they required on a consistent basis with the current staffing mix in the home, PSW #112 said they were able to provide the required care when at full complement but not if they were short. They stated that they received direction from the nurse in situations when there was not a full complement of PSW staff working in the home. When asked if there had been any shifts where they were not able to provide residents with the care that they required due to short staffing, PSW #112 stated every day. PSW #112 continued to state that when working short resident care needs were prioritized, with toileting and answering call bells being the highest priority. PSW #112 said baths were usually missed when working short and they were aware baths had been missed that day due to short staffing.

During interviews on two specific dates, when asked how they would know what care a resident required related to bathing, transferring, toileting and continence care, PSW #104 stated this would be indicated on the residents' care plan and scheduled

baths would be indicated on the bath list at the nursing station. PSW #104 said they would document the care they provided to residents during their shift under tasks on PointofCare (POC). PSW #104 said that residents were to receive two baths per week. They said that if a resident missed a bath it would be documented as Not Applicable (NA) on POC. They stated missed baths were typically also documented on the 24 hour report at the nursing station. They said that made up baths would also be documented on POC under the "Bathing" task scheduled as needed (PRN). When asked how many PSW staff were scheduled on each neighbourhood on day and evening shifts, PSW #104 stated there should be four PSWs per neighbourhood and that they were often working with less than four and typically worked with only two PSWs on a neighbourhood on weekends. When asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW staff working in the home, PSW #104 stated they were used to working short and had just figured out on their own how to get stuff done. They said that when working short they were not able to provide residents with the level of care they would like to be able to give and baths don't get done. PSW #104 stated on the evening shift of the date identified in the complaint, they worked the entire shift as the only staff member on a neighbourhood and were responsible for providing care to all residents on that neighbourhood by themselves. When asked if they were able to provide residents on that neighbourhood with the care they required on this identified date, PSW #104 said they were unable to bath any residents and could not transfer, toilet or change any residents requiring a second staff member for assistance, resulting in five or six residents being left in their chairs and without toileting or continence care the entire shift.

During an interview on a specific date PSW #102 stated they worked the evening shift as the only PSW on a specific neighbourhood on the date identified in the complaint and received help with completing resident care from a registered staff member. They said that when PSW staff were unable to provide required care for a resident they would document "NA" or would not document anything under tasks on POC. PSW #102 stated that residents were regularly missing baths due to short staffing and it would be documented on the 24 hour report at the nursing station when a resident missed their bath.

During an interview on a specific date PSW #107 stated they worked the evening shift as the only staff member on a specific neighbourhood on the date identified in the complaint and were responsible for providing care to all residents on this

neighbourhood themselves.

During an interview on a specific date PSW #114 told inspector #730 that they worked the evening shift on the date identified in the complaint. They said that they were the only PSW between two specific neighbourhoods on that shift and were frustrated with the lack of communication and direction about what was happening. PSW #114 stated that they knew there were at least five residents that were not toileted or changed on one of these neighbourhoods that evening.

During an interview on a specific date RPN #111 said it was normal for care not to be provided on weekend and evening shifts due to short staffing. They said that as a result of short staffing, baths often weren't completed and that sometimes night shift staff would come in and find residents still up because evening shift couldn't transfer them into bed. RPN #111 stated that short staffing was not as much of an issue with registered staff as they were often asked to work overtime hours and management would come in to provide coverage if needed. When asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW or RPN staff working in the home, RPN #111 said that years ago they were provided a back-up plan for what to do when short staffed but the plan didn't tell didn't tell them what to do in situations with only one staff member on each neighbourhood. They stated that when a neighbourhood was short an RPN from another neighbourhood would come complete the medication pass on the short neighbourhood and there would be no RPN on the neighbourhood the remainder of the shift.

During an interview on a specific date, when asked if the home had a back-up plan that addressed situations when there was not a full complement of PSW staff working in the home, RPN #103 stated there was a protocol to follow for when there were five PSWs working between two adjacent neighbourhoods and they otherwise made the plan up on their own because there was no plan for when there were fewer than this. RPN #103 stated there were no PSW staff and they were the only staff member working on a specific neighbourhood on the evening shift on the date identified in the complaint. RPN #103 continued to state that another neighbourhood was short an RPN on this shift and at one point they had to leave their assigned neighbourhood to administer medications on this neighbourhood, at which time the Administrator and DOC came to watch over their neighbourhood. When asked if residents were provided with the care that they required on this shift, RPN #103 stated that with the Administrators assistance they were able to provide some care

for residents, but baths were not completed and some residents were not transferred to bed or toileted and this care was passed to the oncoming night shift.

It was identified through staff interviews and observations conducted throughout the course of the inspection that residents #001, #002, #003, #004, #005, #007 and #010 had specific care needs and that when staffing levels were not at full complement some of these care needs were not being met.

A review of resident #001's Care Plan in PointClickCare (PCC) showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #001 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 31 scheduled occurrences in a specific 54 date period.

A review of resident #001's Progress Notes in PCC showed documentation from the evening shift on a specific date stating that resident #001 missed a scheduled bath the day prior and staff were unable to complete the bath this shift.

A review of resident #002's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #002 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 28 scheduled occurrences in a specific 54 date period.

A review of resident #003's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #003 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 40 scheduled occurrences in a specific 54 date period.

A review of resident #003's Progress Notes in PCC showed documentation from three specific dates stating that resident #003 missed their bath.

A review of resident #004's Care Plan in PCC showed specific interventions related to their transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #004 showed tasks related to transferring, toileting and continence care that were not documented on 64 scheduled occurrences in a specific 54 date period.

During an interview on a specific date, resident #004 told inspector #730 that they had concerns related to the staffing levels in the home. They said that there was only one PSW staff on the neighbourhood when there should have been four on a recent date. They said that they brought their concerns forward to the home's Administrator but felt that their concerns were not addressed. The resident stated that often residents have to go to bed later than they would like as there are not enough staff to transfer them to bed. Regarding bathing, resident #004 said that they have complained numerous times to management that they did not receive their bath at the scheduled time and felt that they only received the care they requested after a complaint was made.

During an interview with a PSW they said they provided resident #004 with specific care related to transferring on the evening shift of the date identified in the complaint, but did not document any of the care provided to them.

A review of resident #005's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #005 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 51 scheduled occurrences in a specific 54 date period.

During an interview with a PSW they said that resident #005 required specific interventions related to toileting and transferring. The PSW said they were working alone on resident #005's neighbourhood on the date identified in the complaint and that this resident did not receive the required care related to their transferring and

toileting needs on this shift.

A review of resident #007's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #007 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 34 scheduled occurrences in a specific 54 date period.

A review of resident #007's Progress Notes in PCC showed documentation from a specific date stating that their bath was not completed that shift.

A review of resident #010's Care Plan in PCC showed specific interventions related to their bathing, transferring, toileting and continence care needs.

A review of the POC report titled "Documentation Survey Report v2" for resident #010 showed tasks related to bathing, transferring, toileting and continence care that were not documented or were documented as "NA" on 115 scheduled occurrences in a specific 54 date period.

On a specific date and time Inspector #721 observed resident #010 requesting specific interventions related to continence care and being told by staff they would have to wait to receive this care as there were not enough staff members available to provide the care. Inspector #721 spoke with resident #010 later this day and they stated they required specific interventions related to continence care and would notify staff when they required this care. Resident #010 said they had waited approximately 15 minutes to receive the specific continence care interventions that day, but some days they had to wait over an hour to receive this care.

During an interview on a specific date, when asked what the expected PSW and RPN staffing levels were in the home, Administrator #100 stated the optimal staffing level was 20 PSWs and five RPNs on each neighbourhood on day and evening shifts, and eight PSWs and two RPNs on night shifts. When asked how it was determined this staffing mix was consistent with meeting the residents' assessed care and safety needs, Administrator #100 stated the expected staffing levels were established before they started working in the home and they were confident that

residents care needs were being met with the full complement of staff. When asked how the home evaluated whether residents care and safety needs were being met, they stated the nursing department would review care being provided and identify gaps in care on a daily basis. Administrator #100 said they were aware there were shifts during the identified 54 date period when the home was not at full complement of PSW staff due to staff calling in and not being able to fill shifts. When asked if the home had a back-up plan that addressed situations when there was only one staff member working in a neighbourhood, Administrator #100 stated they wouldn't necessarily plan for that type of deep crisis and hope it doesn't happen. When asked if they felt the back-up plan effectively met the care needs of the residents in situations where the home was not at full complement of staff, Administrator #100 stated they thought staff were providing safe care to residents but not the same level of care as when they were at full complement. When asked why there were so many unfilled PSW and RPN shifts on the staff schedules during the identified 54 date period, Administrator #100 stated they had tried to fill the shifts by calling staff in and were not able to as they had recently lost several PT PSW's from their roster. They continued to state that the home was actively recruiting new staff to their roster and had started scheduling agency PSW staff in a specific month to ensure PSW staffing levels were at full complement until they could recruit enough staff to adequately fill these shifts. When asked if they had received any complaints related to the care that was provided to residents during the identified time period when the home was short staffed, Administrator #100 stated they had not received any formal complaints but that concerns had been raised over staffing levels and they had followed up to rectify each concern when care wasn't met.

The licensee failed to ensure that the written staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs for PSW staff on 50 of 54 day shifts, 53 of 54 evening shifts and 38 of 54 night shifts, and for RPN staff on 10 of 54 day shifts, 10 of 54 evening shifts and three of 54 night shifts reviewed, and included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work and there are less than five PSWs between two neighbourhoods on a shift.

The severity of this issue was determined to be a level three as there was actual risk to the residents. The scope of the issue was a level two as it related to 164 of 324 (50%) shifts reviewed. The home had a level two compliance history as they had previous non-compliance to a different subsection in the last 36 months. (721)

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 : Jun 30, 2020(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

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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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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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 20th day of April, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by MEAGAN MCGREGOR (721) - (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