Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
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Téléphone: (888) 432-7901
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2020_793743_0003 (A1)	024517-19, 000200-20, 000775-20, 000776-20	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

Amended by KIYOMI KORNETSKY (743) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CDD extended to July 31, 2020, due to COVID-19 outbreak.

Issued on this 25th day of May, 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

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

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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
May 25, 2020	2020_793743_0003 (A1)	024517-19, 000200-20, 000775-20, 000776-20	Critical Incident System

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45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

Amended by KIYOMI KORNETSKY (743) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 27-31, 2020 and February 3-7, 2020.

The following intakes were completed in this Critical Incident System inspection:

Log #024517-19 / log #000200-20 / and log #000775-20 related to falls that resulted in a significant change in status;

Log #000725-20 complaint related to an improper transfer;

Log #000776-20 related to improper medication administration.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 20(1), identified in a concurrent inspection #2020_793743_0003 (Log #000725-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Behaviour Support Ontario (BSO) Nurse, Pharmacy technician, Pharmacist, Coroner, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Substitute Decision Makers (SDM).

The inspector(s) reviewed clinical records for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations and relevant employee files.

Observations were made of residents, the home's medication administration and management system, staff to resident interaction and resident care provision.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 VPC(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) reported an incident involving a resident that resulted in an injury.

At the time of the injury, it was noted that specific interventions for resident #003 were not in place.

Resident #003's plan of care identified the resident with a number of responsive behaviours and they were at high risk for falling. At the time of the fall, it was noted that specific interventions for resident #003 were not in place.

PSW #101 said they were to implement a specific intervention on the day of the incident involving resident #003; however, PSW #100 and RN #102 said the specific interventions for resident #003's were not in place prior to the fall involving resident #003.

Resident #003's medical certificate of death documented their immediate cause of death was consequences related to the injuries they sustained as a result of the fall.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) reported an incident involving a resident that resulted in an injury.

At the time of the injury, it was noted that specific interventions for resident #003 were not in place.

Resident #003's plan of care identified the resident with a number of responsive behaviours and they were at high risk for falling. At the time of the fall, it was noted that specific interventions for resident #003 were not in place.

PSW #101 said they were to implement a specific intervention on the day of the incident involving resident #003; however, PSW #100 and RN #102 said the specific interventions for resident #003's were not in place prior to the fall involving resident #003.

Resident #003's medical certificate of death documented their immediate cause of death was consequences related to the injuries they sustained as a result of the fall.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that it was complied with.

In accordance O.Reg.79/10, s.114(2), and in reference to 114(1), the licensee was required to ensure that written policies and protocols were developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy titled Narcotics and Controlled Substances, last revised on June 27, 2019, directed staff to refer to SilverFox Pharmacy:LTC Policy and Procedure Manual Section – Drug Administration; which indicated that prior to administration of controlled substances, staff were to verify the medication that was to be administered for accuracy against the eMar; were to document the date and time, administration quantity, remaining quantity and signature of staff administering the medication on the Controlled Substance Administration record. The policy also directed staff to document on the eMar immediately after the medication was administered prior to moving on to the next resident.

A) A CI was submitted related to a medication error involving resident #001. Resident #001 was prescribed a certain dose of medication, however, Agency Registered Practical Nurse (RPN) #109 allegedly administered an incorrect dose of the prescribed medication.

Medication orders documented in resident #001's chart, as well as in PCC, ordered that resident #001 receive a specific dose of a medication every 4 hours as needed (PRN) for discomfort.

According to Agency RPN #109, on the day of the incident, NP #125 asked them to administer a PRN dose of the medication to resident #001.

Agency RPN #109 said they had never administered the medication before and were nervous. They said on the day of the incident, without looking at the medication order or the resident's eMAR, they drew up the medication and administered the medication to resident #001. As per the resident's eMar and the resident's Controlled Substance Administration Record, their dosing was incorrect.

Agency RPN #109 said the only reason why they knew to administer that particular medication to resident #001, was because NP #125 had asked them to.

Agency RPN #109 also noted that being unfamiliar with the home's medication documentation process, they did not document the medication administration.

Record review of resident #001's eMAR, as well as the resident's Controlled Substance Administration Record, noted that Agency RPN #109 did not sign on the day of the incident for the medication administered to resident #001. RPN #128 also noted that Agency RPN #109 had not signed for the medication that had been administered to resident #001.

DRC #112 said that Agency RPN #109 did not document on resident #001's eMar after they administered the ordered medication on the day of the incident and five days later, the home became aware that Agency RPN #109 had administered incorrectly the prescribed dose of medication to resident #001.

B) A Medication incident was submitted to Silver Fox Pharmacy, indicated that Agency RPN #109 did not administer a specific medication to resident #007, however, they signed that the medication had been administered.

Resident #007's eMAR records indicated that the prescribed dose of medication had been signed as administered; however, the Controlled Substance Shift Count LTC records indicated the medication had not been provided to resident #007.

When asked about the medication incident, DRC #112 acknowledged that Agency RPN #109 did not administer the medication to resident #007.

The licensee failed to ensure that the home's Narcotics and Controlled

Substances Policy was complied with, when Agency RPN #109 failed to verify two different medications for accuracy against the eMAR, prior to administering the medication to resident #001 and resident #007 respectively. Agency RPN #109 also failed to document the medication administered to resident #001 on the eMAR; and incorrectly documented that they had administered a medication to resident #007, when in fact, they had not. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 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# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place

any procedure, that it was complied with.

In accordance O.Reg.79/10, s.114(2), and in reference to 114(1), the licensee was required to ensure that written policies and protocols were developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy titled Narcotics and Controlled Substances, last revised on June 27, 2019, directed staff to refer to SilverFox Pharmacy:LTC Policy and Procedure Manual Section – Drug Administration; which indicated that prior to administration of controlled substances, staff were to verify the medication that was to be administered for accuracy against the eMar; were to document the date and time, administration quantity, remaining quantity and signature of staff administering the medication on the Controlled Substance Administration record. The policy also directed staff to document on the eMar immediately after the medication was administered prior to moving on to the next resident.

A) A CI was submitted related to a medication error involving resident #001. Resident #001 was prescribed a certain dose of medication, however, Agency Registered Practical Nurse (RPN) #109 allegedly administered an incorrect dose of the prescribed medication.

Medication orders documented in resident #001's chart, as well as in PCC, ordered that resident #001 receive a specific dose of a medication every 4 hours as needed (PRN) for discomfort.

According to Agency RPN #109, on the day of the incident, NP #125 asked them to administer a PRN dose of the medication to resident #001.

Agency RPN #109 said they had never administered the medication before and were nervous. They said on the day of the incident, without looking at the medication order or the resident's eMAR, they drew up the medication and administered the medication to resident #001. As per the resident's eMar and the resident's Controlled Substance Administration Record, their dosing was incorrect.

Agency RPN #109 said the only reason why they knew to administer that particular medication to resident #001, was because NP #125 had asked them to.

Agency RPN #109 also noted that being unfamiliar with the home's medication documentation process, they did not document the medication administration.

Record review of resident #001's eMAR, as well as the resident's Controlled Substance Administration Record, noted that Agency RPN #109 did not sign on the day of the incident for the medication administered to resident #001. RPN #128 also noted that Agency RPN #109 had not signed for the medication that had been administered to resident #001.

DRC #112 said that Agency RPN #109 did not document on resident #001's eMar after they administered the ordered medication on the day of the incident and five days later, the home became aware that Agency RPN #109 had administered incorrectly the prescribed dose of medication to resident #001.

B) A Medication incident was submitted to Silver Fox Pharmacy, indicated that Agency RPN #109 did not administer a specific medication to resident #007, however, they signed that the medication had been administered.

Resident #007's eMAR records indicated that the prescribed dose of medication had been signed as administered; however, the Controlled Substance Shift Count LTC records indicated the medication had not been provided to resident #007.

When asked about the medication incident, DRC #112 acknowledged that Agency RPN #109 did not administer the medication to resident #007.

The licensee failed to ensure that the home's Narcotics and Controlled Substances Policy was complied with, when Agency RPN #109 failed to verify two different medications for accuracy against the eMAR, prior to administering the medication to resident #001 and resident #007 respectively. Agency RPN #109 also failed to document the medication administered to resident #001 on the eMAR; and incorrectly documented that they had administered a medication to resident #007, when in fact, they had not. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 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# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that it was complied with.

In accordance O.Reg.79/10, s.114(2), and in reference to 114(1), the licensee was required to ensure that written policies and protocols were developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy titled Narcotics and Controlled Substances, last revised on June 27, 2019, directed staff to refer to SilverFox Pharmacy:LTC Policy and Procedure Manual Section – Drug Administration; which indicated that prior to administration of controlled substances, staff were to verify the medication that was to be administered for accuracy against the eMar; were to document the date and time, administration quantity, remaining quantity and signature of staff administering the medication on the Controlled Substance Administration record.

The policy also directed staff to document on the eMar immediately after the medication was administered prior to moving on to the next resident.

A) A CI was submitted related to a medication error involving resident #001. Resident #001 was prescribed a certain dose of medication, however, Agency Registered Practical Nurse (RPN) #109 allegedly administered an incorrect dose of the prescribed medication.

Medication orders documented in resident #001's chart, as well as in PCC, ordered that resident #001 receive a specific dose of a medication every 4 hours as needed (PRN) for discomfort.

According to Agency RPN #109, on the day of the incident, NP #125 asked them to administer a PRN dose of the medication to resident #001.

Agency RPN #109 said they had never administered the medication before and were nervous. They said on the day of the incident, without looking at the medication order or the resident's eMAR, they drew up the medication and administered the medication to resident #001. As per the resident's eMar and the resident's Controlled Substance Administration Record, their dosing was incorrect.

Agency RPN #109 said the only reason why they knew to administer that particular medication to resident #001, was because NP #125 had asked them to.

Agency RPN #109 also noted that being unfamiliar with the home's medication documentation process, they did not document the medication administration.

Record review of resident #001's eMAR, as well as the resident's Controlled Substance Administration Record, noted that Agency RPN #109 did not sign on the day of the incident for the medication administered to resident #001. RPN #128 also noted that Agency RPN #109 had not signed for the medication that had been administered to resident #001.

DRC #112 said that Agency RPN #109 did not document on resident #001's eMar after they administered the ordered medication on the day of the incident and five days later, the home became aware that Agency RPN #109 had administered incorrectly the prescribed dose of medication to resident #001.

B) A Medication incident was submitted to Silver Fox Pharmacy, indicated that Agency RPN #109 did not administer a specific medication to resident #007, however, they signed that the medication had been administered.

Resident #007's eMAR records indicated that the prescribed dose of medication had been signed as administered; however, the Controlled Substance Shift Count LTC records indicated the medication had not been provided to resident #007.

When asked about the medication incident, DRC #112 acknowledged that Agency RPN #109 did not administer the medication to resident #007.

The licensee failed to ensure that the home's Narcotics and Controlled Substances Policy was complied with, when Agency RPN #109 failed to verify two different medications for accuracy against the eMAR, prior to administering the medication to resident #001 and resident #007 respectively. Agency RPN #109 also failed to document the medication administered to resident #001 on the eMAR; and incorrectly documented that they had administered a medication to resident #007, when in fact, they had not. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 005 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# 005

Issued on this 25th day of May, 2020 (A1)

[redacted]

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 KIYOMI KORNETSKY (743) - (A1)
Inspection No. / No de l'inspection :	2020_793743_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024517-19, 000200-20, 000775-20, 000776-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 25, 2020(A1)
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Grace Manor 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Dykstra

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Holland Christian Homes Inc., 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically the licensee must:

a) Ensure that all residents are provided care as specified in their plan of care, specific to responsive behaviors.

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. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) reported an incident involving a resident that resulted in an injury.

At the time of the injury, it was noted that specific interventions for resident #003 were not in place.

Resident #003's plan of care identified the resident with a number of responsive behaviours and they were at high risk for falling. At the time of the fall, it was noted that specific interventions for resident #003 were not in place.

PSW #101 said they were to implement a specific intervention on the day of the incident involving resident #003; however, PSW #100 and RN #102 said the specific interventions for resident #003's were not in place prior to the fall involving resident #003.

Resident #003's medical certificate of death documented their immediate cause of death was consequences related to the injuries they sustained as a result of the fall.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The severity of the issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had ongoing non-compliance that included:
- Voluntary Plan of Correction (VPC) issued May 17, 2019 (2017_508137_0027)
(606)

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

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

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

The Licensee must be compliant with s.76 (2) of the LTCHA.

Specifically, the licensee must:

a) Ensure that all registered staff, including agency registered staff, receive training and orientation according to s.76 (2) of the LTCHA, including the medication administration processes and policies. Documentation of the completed education should be kept in the home.

b) Ensure that agency RPN #109, #120 and #122, and all new registered staff, including agency staff, have completed their orientation and required shadow shifts, prior to being scheduled to work independently at the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all registered staff received orientation training before performing their responsibilities, including training about the Act, regulations and policies of the Ministry and similar dcuments, including policies of the licensee that are relevant to the person's responsibilities, and any other areas provided for in the regulation.

A) A CI was submitted related to a medication error involving resident #001. Agency Registered Practical Nurse (RPN) #109 was documented as administering the prescribed dose of a specific medication incorrectly to resident #001.

According to Director of Resident Care (DRC) #112, RPNs were responsible for several tasks in the home, including medication and narcotic administration, and documentation.

DRC #112 said the employment agencies were responsible for training agency registered staff about the home's general policies and procedures; and agency registered staff were offered a shadow shift prior to working independently at the home. It was during this shadow shift that agency registered staff would review the home's policies and procedures related to medication and narcotic administration and documentation.

DRC#112 said they had no way of knowing who the agency was sending; and had trusted the agencies to send registered staff that had completed their orientation.

They also said that the completion of the shadow shift and orientation of the home's policies and procedures was not tracked by the home.

Medication orders in resident #001's chart, as well as in Point Click Care (PCC), ordered that resident #001 receive a specific medication every 4 hours (Q4H), as needed (PRN), for discomfort. The Medication was dosed in a specific amount per one milliliter (ml) vials.

According to the home's investigative notes and interviews with Agency RPN #109 and Nurse Practitioner (NP) #125; on the date of the incident, NP #125 asked Agency RPN #109 to administer a PRN dose of the ordered medication to resident #001. Agency RPN #109 informed NP #125 that they were new to the home, did not know where the syringes were kept, and were behind on their morning medication administration.

NP #125 proceeded to find a syringe for Agency RPN #109, and informed the Assistant Director of Resident Care (ADRC) #126 that Agency RPN #109 required assistance. NP#125 confirmed that they witnessed Agency RPN #109 remove the medication vials, but did not observe Agency RPN #109 drawing up the dose.

The home's investigative notes documented that ADRC #126 arrived on the unit thirty minutes after NP #125 informed them that Agency RPN #109 was overwhelmed. They said they found Agency RPN #109 outside resident #001's room, and it was at this point that Agency RPN #109 informed ADRC #126 that they had not received orientation to the home, nor had they received orientation about any of the home's policies and procedures.

According to the home's investigative notes, ADRC #126 informed DRC #112 that Agency RPN #109 could not work independently as they had not received orientation. After speaking with DRC #112, ADRC #126 observed that Agency RPN #109 had already drawn up the medication in a syringe and instructed the Agency RPN #109 to administer the medication to resident #001.

ADRC #126 was called into resident #001's room, where they noted that Agency RPN #109 did not know how to administer the medication. ADRC #126 said they provided instructions and while Agency RPN #109 was administering the medication to resident #001, resident #001's family member questioned if Agency RPN #109

was a student.

Agency RPN #109 confirmed that they did not receive orientation about the home's policies or procedures, nor orientation to the home, prior to their shift that day. They said ADRC #126 did not double check the dose of medication in their syringe, even after informing ADRC #126 that they were practicing in the home without any orientation. In addition, prior to that day, Agency RPN #109 said they had never administered the prescribed medication, nor had they used PCC, which was the home's medication administration and documentation system.

Agency RPN #109 reported that on the day of the incident, they were provided with access codes to PCC, were asked to co-sign a narcotic sheet and were then left on their own.

When asked how much medication they were supposed to administered to resident #001, Agency RPN #109 said they did not know, as they had not looked at the medication orders or the electronic Medication Record (eMAR). They said that they drew up the incorrect dose of medication and administered it to resident #001. They also noted that being unfamiliar with the home's medication documentation process, they did not document the medication administered.

Later that day, RPN #128 reported they informed ADRC #126 that Agency RPN #109 had not documented for the medication administered to resident #001. Five days later, Agency RPN #109 returned to the home to sign the appropriate documentation, and it was at this point that the home realized resident #001 had not received the prescribed dose. In total, on the day of the incident, Agency RPN #109 completed 19 medications errors, including the medication error involving resident #001.

According to DRC #112, registered staff were required to complete orientation in order to be deemed safe to practice in the home; and agency registered staff were not allowed to work independently in the home without prior orientation, as this was considered unsafe.

When asked if it had been safe for Agency RPN #109 to work independently without any orientation; DRC #112 said the agency should not have sent Agency RPN #109. They also said that prior to the incident, they had not received nor reviewed any documentation about the training or orientation provided to Agency RPN #109.

DRC #112 could not answer why ADRC #126 allowed Agency RPN #109 to practice in the home and even instructed Agency RPN #109 to independently administer the medication to resident #001, after becoming aware that Agency RPN #109 had not received any prior orientation.

Resident #001 passed away an identified amount of time after receiving the incorrect dose of medication. According to Coroner #123 resident #001's death was likely a result of the medication error, as well as the multiple injuries the resident sustained from a separate incident.

B) Agency RPN #120 reported that they had worked approximately two or three shifts at the home. They said their employment agency had not provided them with any orientation about the homes policies or procedures. They had received a shift orientation at the home, and said the staff at the home reviewed the home's medication system, process and procedures for medication administration and narcotic administration.

When asked if the they could recall what the home's process was for medication administration, Agency RPN #120 questioned how they were supposed to know this information as they were not employees of the home.

DRC #112 could not provide any documentation about Agency RPN #120's orientation.

When asked how the home ensured that staff at the home were orienting Agency RPNs to the home's medication administration policies and relevant polices not covered by the agencies; DRC #112 replied that they had no supporting documentation.

C) Agency RPN #122 reported that they had worked an identified number of shifts at the home; and said their employment agency e-mailed them polices to review, however, the policies were not specific to the home.

Agency RPN #112 said they received an orientation shift at the home, and though the staff member discussed the medication system and process with them, they did not read, nor were they shown the home's medication administration or controlled

substance policies.

DRC #112 provided a checklist that was completed by the employment agency; which identified the general policies Agency RPN #122 had reviewed. DRC #112, however, could not determine if the policies Agency RPN #122 had reviewed were the home's polices or the employment agency's policies.

The licensee has failed to ensure that staff did not perform their responsibilities prior to receiving training; when Agency RPN #109, Agency RPN #122 and Agency RPN #120 worked at the home prior to receiving orientation. [s. 76. (2)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 3 as it related to all three of three registered staff reviewed. The home had a level 2 compliance history they had previous non-compliance related to a different subsection. (743) (743)

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

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: 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting residents.

A) A complaint was submitted related to an incident involving resident #005, after they were improperly transferred.

Resident #005's plan of care at the time of the incident indicated that the resident required a specific type of transfer equipment that required two staff assistance.

PSW #117 stated that resident #005 always required a specific type of equipment with two staff assistance for transfers. They also stated that the resident's transfer requirements were clearly posted above the resident's bed and the transfer equipment always required two staff to operate.

Observation of resident #005's bedroom showed a sign above their bed indicating that the resident required total assistance for their transfers when using a specific type of transfer equipment.

On the day of the incident, PSW #118 transferred resident #005 using an incorrect piece of transfer equipment, and did not have assistance from two staff members.

PSW #117 stated that PSW #118 informed them they had used the incorrect equipment when transferring the resident. The resident was noted to complain of discomfort and distress as a result of the incident.

The Director of Resident Care (DRC) #112 said that resident #005 was transferred with the incorrect piece of equipment and two staff members should have been present. (753) [s. 36.]

2. B) A CI was submitted stating that resident #001 sustained an injury after an incident involving a transfer device. The resident passed away as a result of their injuries.

Documentation indicated that PSW #116 was providing care to resident #001 when an incident occurred involving a transfer device. Resident #001 had been left alone while in the transfer device and as a result sustained multiple injuries that required hospital care.

Resident's #001's plan of care indicated the resident required one staff assistance for care and two staff members to assist with all aspects related transfer equipment.

PSW #116 said they left resident #001 alone and did not use the call bell to get assistance with the resident's transfer. PSW #116 also said they operated the transfer lift themselves.

In an interview with PSW #103, #114 and #115, they all stated that if a resident required one-person assistance with certain care activities, the associated transfer equipment could be operated by one person when transferring, unless otherwise indicated in the resident's plan of care.

The home's policy titled, "Resident Safe Handling Program", last revised February 22, 2017, indicated that mechanical lifting of any residents was to always be completed with the assistance of at least two staff members.

The home's investigative notes concluded that residents should not be left alone when care was being provided is specific areas of the home, and that the call bell should have been used to call for assistance.

In an interview, DRC#112 also stated that resident #001 should not have been left alone, the call bell should have been used to get assistance; and two staff members were required to be present at all times when operating a mechanical lift. (758)

The licensee failed to ensure that staff used safe transferring devices and techniques when assisting resident #001 and #005. [s. 36.]
The severity of the issue was a level 3, as it was actual harm to the residents. The scope of the issue was a level 2, as it related to two of three residents reviewed. The home had a level 3 of compliance history that included:
-VPC issued May 12, 2017 (2017_449619_0007).

(753)

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

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: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure that registered staff comply with the Narcotics and Controlled Substances Policy when administering narcotics to resident #007 and any other resident.

b) Ensure that all registered staff are complying with the home's Narcotic and Controlled Substances Policy when completing the narcotic count.

c) Ensure the Controlled Substance Process Audit tool includes a section that addresses the monitoring of narcotic waste as per the home's Narcotic and Controlled Substances Policy. The audit should be documented and include who is responsible, the results and the actions taken in relation to the results.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that it was complied with.

In accordance O.Reg.79/10, s.114(2), and in reference to 114(1), the licensee was required to ensure that written policies and protocols were developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy titled Narcotics and Controlled Substances, last revised on June 27, 2019, directed staff to refer to SilverFox Pharmacy:LTC Policy and Procedure Manual Section – Drug Administration; which indicated that prior to administration of controlled substances, staff were to verify the medication that was to be administered for accuracy against the eMar; were to document the date and time, administration quantity, remaining quantity and signature of staff administering the medication on the Controlled Substance Administration record. The policy also directed staff to document on the eMar immediately after the medication was administered prior to moving on to the next resident.

A) A CI was submitted related to a medication error involving resident #001. Resident #001 was prescribed a certain dose of medication, however, Agency Registered Practical Nurse (RPN) #109 allegedly administered an incorrect dose of the prescribed medication.

Medication orders documented in resident #001's chart, as well as in PCC, ordered that resident #001 receive a specific dose of a medication every 4 hours as needed (PRN) for discomfort.

According to Agency RPN #109, on the day of the incident, NP #125 asked them to administer a PRN dose of the medication to resident #001.

Agency RPN #109 said they had never administered the medication before and were nervous. They said on the day of the incident, without looking at the medication order or the resident's eMAR, they drew up the medication and administered the medication to resident #001. As per the resident's eMar and the resident's Controlled Substance Administration Record, their dosing was incorrect.

Agency RPN #109 said the only reason why they knew to administer that particular medication to resident #001, was because NP #125 had asked them to.

Agency RPN #109 also noted that being unfamiliar with the home's medication documentation process, they did not document the medication administration.

Record review of resident #001's eMAR, as well as the resident's Controlled Substance Administration Record, noted that Agency RPN #109 did not sign on the day of the incident for the medication administered to resident #001. RPN #128 also noted that Agency RPN #109 had not signed for the medication that had been administered to resident #001.

DRC #112 said that Agency RPN #109 did not document on resident #001's eMar after they administered the ordered medication on the day of the incident and five days later, the home became aware that Agency RPN #109 had administered incorrectly the prescribed dose of medication to resident #001.

B) A Medication incident was submitted to Silver Fox Pharmacy, indicated that Agency RPN #109 did not administer a specific medication to resident #007, however, they signed that the medication had been administered.

Resident #007's eMAR records indicated that the prescribed dose of medication had been signed as administered; however, the Controlled Substance Shift Count LTC records indicated the medication had not been provided to resident #007.

When asked about the medication incident, DRC #112 acknowledged that Agency RPN #109 did not administer the medication to resident #007.

The licensee failed to ensure that the home's Narcotics and Controlled Substances Policy was complied with, when Agency RPN #109 failed to verify two different medications for accuracy against the eMAR, prior to administering the medication to resident #001 and resident #007 respectively. Agency RPN #109 also failed to document the medication administered to resident #001 on the eMAR; and incorrectly documented that they had administered a medication to resident #007, when in fact, they had not. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 2 compliance history they had previous

non-compliance related to a different subsection. (743) (743)

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

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: 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)

Grounds / Motifs :

1. 1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A CI was submitted related to a medication incident involving resident #001. Resident #001 was ordered a specific dose of medication and Agency RPN #109 allegedly administered an incorrect dose.

Medication orders written in resident #001's chart, as well as in PCC, ordered that a specific medication be administered Q4H PRN for pain.

According to Agency RPN #109, on the day of the incident, NP #125 asked Agency RPN #109 to administer a PRN dose of the medication to resident #001.

When asked what dose of medication resident #001 was prescribed, Agency RPN #109 said they did not know, as they had not checked the resident's medication orders prior to drawing up the medication. Agency RPN #109 said they drew up and administered an incorrect dose of the medication.

DRC #112 confirmed that on the day of the medication incident, Agency RPN #109 administered an incorrect dose of medication to resident #001.

Resident #001 passed away an identified amount of time after receiving the incorrect dose of medication. According to Coroner #123, resident #001's death was likely as a result of the medication error, as well as the multiple injuries the resident had sustained from a separate incident.

B) According to the physician's orders and records in PCC, resident #007 was ordered a specific medication to be administered routinely three times a day.

A medication incident was submitted to Silver Fox Pharmacy, indicating that Agency RPN #109 signed that they had administered resident #007's morning dose of a particular medication, when in fact, they had not.

The Controlled Substance Shift Count LTC confirmed that resident #007 had not received the prescribed dose of medication; and DOC #112 acknowledged that Agency RPN #109 did not administer resident #007's morning dose of medication.

C) Resident #008 was prescribed a time specific medication that was to be administered every morning.

Progress notes from the day of the incidentd ocumented that resident #007 received their morning dose of a time specific medication over four hours late.

A medication incident submitted to Silver Fox Pharmacy, also noted that resident #008 did not receive their morning dose of a specific medication. As a result of the medication error, Physician #129 ordered changes to the resident's time specific afternoon medication in order to compensate for the medication error.

DRC #112 also confirmed that resident #008 did not receive their morning dose of a specific medication as prescribed.

The Licensee failed to ensure that resident #001, #007 and #008 received their medications as prescribed. [s. 131. (2)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 3 as it related to three out of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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-Voluntary Plan of Correction (VPC) issued May 12, 2017 (2017_449619_0007) (743)

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

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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 25th day of May, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KIYOMI KORNETSKY (743) - (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

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