Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300


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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 6, 2019 | 2019_778563_0030 | 012799-19, 015320-19 | Critical Incident System |

## Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Glendale Crossing
3030 Singleton Avenue LONDON ON N6L 0B6

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

MELANIE NORTHEY (563)

## 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): August 15, 16, 19, 21 and 22, 2019**

**During the course of the inspection, the inspector(s) spoke with the General Manager, the Acting Director of Nursing Care, the Assistant Director of Nursing Care, the Executive Vice President Eldercare of Novo Peak Health Incorporated, the Exercise Therapist, the Physiotherapist, the Physiotherapy Assistant, Registered Practical Nurses, Personal Support Workers and residents.**

**The inspector also made observations of residents and care provided. Relevant assessments, plans of care, progress notes, medication and treatment administration records, internal investigation records, policies and procedures were reviewed.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident was protected from abuse by anyone and

free from neglect by the licensee or staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The Critical Incident System report documented an incident where a resident sustained multiple injuries. The family member also wished to file a formal complaint.

The Schlegel Villages Resident/Family Complaint Response Form documented a reported concern from the resident's family member related to the resident's injuries. There was a meeting with the family and the home's management to discuss the possibility that the resident's injuries were after the administration of a specific therapeutic intervention.

The home's investigation notes included an interview with the Registered Practical Nurse (RPN) on shift the date of the incident. The RPN did not complete a documented weekly skin observation or a Pain Assessment in Advanced Dementia Scale (PAINAD) in Point Click Care (PCC). A referral to the Skin and Wound Lead and the Registered Dietitian was not completed in PCC. The interview documented that the RPN forgot to implement the physician's orders to treat the resident's injuries and the physician's order was not documented as part of the resident's Treatment Administration Record (TAR) for three days.

The TAR Schedule documented an order for the resident to receive treatment for their injuries. There was no documented administration of a treatment in the TAR for three days after the incident. A communication progress note in PCC documented the treatment was provided the next day. There should have been immediate treatment and interventions to promote healing and prevent infection as required.

The General Manager (GM) and Acting Director of Nursing Care (DNC) stated they believed the the injuries to the resident was a result of the administration of a specific therapeutic intervention. The GM stated they emailed Novo Peak Health with questions related to their processes related to the hydrocollator, temperatures, assessments, application, quality assurance and documentation of therapy. Novo Peak Health Incorporated was the company that provided physiotherapy and occupational therapy to the residents in the home. The DNC stated the Physiotherapist Assistants (PTAs) were

not documenting in PCC like they should have been and the expectation and agreement with Novo Peak was that the documentation was to be completed in PCC related to the therapy provided. The GM stated a report was sent from Novo Peak to the home that documented their investigation. The GM shared that the discrepancies with the home's investigation prompted escalation to the support office and the Director of Purchasing, the Director of Operations, the Vice President of Support Office Services, and the Head Nurse Consultant for Schlegel Villages.

The Novo Peak "Family Concern at The Village of Glendale Crossing Submitted by Executive Vice President (VP) – Eldercare" was emailed to the General Manager. The data gathering identified that a Physiotherapy Assistant (PTA) had not consistently checked the resident's skin integrity before and after the application of a specific therapy, the therapy had been implemented for varying intervals of time, and the temperature verification of the hydrocollator was not consistently measured on each day of use as required.

A written statement was provided by the PTA explained the events involving the resident. The PTA provided the specific therapeutic intervention in the television (TV) room and then left the resident to see another resident in the same neighbourhood. Once the other resident's physiotherapy program was finished after 15 minutes, the PTA returned to remove the intervention from the resident. The resident was found in their room in bed and the PTA noted the therapeutic intervention was removed. A timer was not used to adhere to the prescribed therapy administration times, the resident was not monitored during the therapy and the resident was not assessed before and after the therapy. The resident did not have personal access to a call bell while sitting in the TV area should the therapy require removal. The PTA's written statement stated it was unusual to see the resident in bed during the day, but there was no follow up with the nursing team members regarding this change.

A written statement by the Personal Support Worker (PSW) documented that the resident was found in their room with a therapeutic intervention in place. The PSW removed it and the resident was transferred back to bed by two PSWs.

One of the PSWs stated they were familiar with the care of the resident and could recall the incident. The PSW stated the resident was in their room and was observed with the specific therapeutic intervention in place. The PSW shared, to the best of their memory, that the resident was transferred back to bed as this was the typical routine. The PSW stated the specific therapeutic intervention was placed on top of the resident's pants. The

PSW remembered the therapy was removed and the resident was transferred back to bed with two staff. There was no PTA in the room and the resident did not seem to be in pain or discomfort at that time. The PSW also shared there have been several times where the PSWs would go into the residents' rooms and there would be the specific therapy in place and the PSWs would not know when it was applied or how long it had been there; and sometimes the residents would be in the common area with the specific therapy in place with no PTA present.

The Novo Peak Health Physiotherapy Policy and Procedure stated, "Observe the skin of the area to be treated prior to beginning to ensure it is intact". The policy instructed to "provide a call bell so that the resident can ring should they require assistance" and "observe the skin".

The Pain Assessment in Advanced Dementia Scale (PAINAD) Extension-SV assessment was completed and documented in PCC by the RPN eight days after the incident.

The Schlegel Villages Pain Management Program Tab 04-48 described pain as "an unpleasant subjective experience that can be communicated to others through self-report when possible and/or a set of pain-related behaviours; it is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." The Registered Team were to complete and document a pain assessment in PCC "when there are personal expressions exhibited by resident that may be an indicator for the onset of pain" or "when there is a change in condition with pain onset" or "when report from resident, family, team member volunteers that pain is present". According to the home's pain management program, the resident was to be assessed the day of the incident when the injury caused pain.

The TAR and physician's order to treat a specific area was not updated to reflect other areas of injury identified. The Assistant Director of Care (ADNC) completed a skin assessment and initiated a new order and completed the first documented PAINAD assessment since the incident. A Dietitian Referral was also sent by the ADNC and the Registered Dietitian (RD) assessed the resident six days after the onset of pain and injury. Also, there was a new intervention to hold the therapeutic intervention.

The Weekly Skin Observation Tool - SV2 - V 2 assessment was completed and documented in PCC by the RPN eight days after the incident.

Approximately 14 days after the incident the resident continued to have increased pain,

had acquired wound infections and was no longer receiving physiotherapy exercises that proved effective. The physician had increased pain management medications and the route for administration.

The scheduled treatment for a new specialized intervention was not scheduled as part of the TAR, therefore there was no schedule attached to the order to flag the nurses to administer the treatment at the prescribed times. The ADNC stated the nurse would not know that the treatment was due and there was no documentation when the treatment was last administered. There was no documented evidence that the treatment was implemented as ordered by the physician.

The resident then sustained another injury during care and there was no documented evidence that the resident's acting Power of Attorney (POA) was informed of the injury. There was no TAR documentation or progress note to state that the resident received the treatment to the new injured area on two separate dates as prescribed. The resident was also administered an inappropriate treatment intervention to their original injury that was not prescribed. There was no weekly skin observation completed in PCC for 11 days.

The Assistant Director of Nursing care (ADNC) stated the RPN observed the resident's skin and received the physician's order, started the treatment but did not enter the order in the Treatment Administration Record (TAR) on the date of the incident. The ADNC could not provide documented evidence of the type of treatment started immediately and stated the "Referral to Skin Care Lead - SV2" should have been completed the day the injury was identified. The ADNC shared that the referral would remind the registered nursing team to complete the following:
- Type of Skin Issue,
- Description and treatment used (if applicable),
- Treatment added to TAR (date and time),
- Weekly Skin Observation Tool implemented (date and time),
- Resident/SDM Notified (date and time),
- Physician Notified (date and time), and
- Referral to Dietician completed (date and time).

The ADNC verified that if the RPN completed the "Referral to Skin Care Lead - SV2" as outlined in the "Process of New Skin Concerns" they would have been reminded to also complete a TAR, a skin observation assessment in PCC, a PAINAD and referral to the RD and this was not completed.

The Schlegel Villages Treatment Records tab 05-40 stated, "treatments are arranged in

the treatment record" and "once the treatment is completed, all treatments will be signed on the Treatment Administration record (TAR) by the team member completing the treatment." The new specialized treatment intervention was not documented as administered because it was never arranged as a treatment record.

The Remedy's Rx Documentation of orders Policy No. 4.8 last revised August 15, 2018 stated, "As soon as possible after receiving the order, the registered staff check the order for completeness" and transcribe to the administration record.

The Schlegel Villages Skin and Wound Care Program Tab 04-78 stated the Registered Nurse and Registered Practical Nurse "communicates with resident and/or substitute decision maker, and the Village team regarding skin and wound issues" and "completes pain assessment as appropriate". The skin and wound program instructs the registered team members to assess altered skin integrity including skin breakdown and to refer to the Dietitian using the Dietitian referral form. "The registered team member will conduct an assessment and document that assessment" in PCC "when there is a change in skin integrity and weekly thereafter until it is healed." The Personal Support Workers "reports and documents abnormal or unusual skin concerns to the registered nursing team member, including but not limited to red or open areas, blisters, bruises, tears, scratches."

The home's skin and wound program included specific guidelines for assessment, interdisciplinary follow up and documentation. The registered staff failed to follow the "Process of New Skin Concerns" in providing the resident with the care and treatment immediately after the discovery of their injuries.

At the time of the incident, the care plan for the resident in PCC documented a specific therapeutic intervention to be administered for a specific amount of time. The Physiotherapist Assistant would implement the interventions as part of the resident's plan of care and would document the therapy in Colligo. The Colligo report had a "minutes" column which represented the amount of time the Physiotherapy Assistant spent preparing for the administration of the therapy. The "supervised" column indicated the direct time the therapy was applied.

The Colligo report documented that 69 per cent of the time the resident was provided the intervention for a longer period than prescribed by the Physiotherapist. On the date of the incident the resident received the therapy for twice as long as prescribed by the Physiotherapist.

The Exercise Therapist (ET) verified a PTA can not adjust the implementation of an intervention ordered by the Physiotherapist (PT). The ET stated the PTAs were never to increase the application time and verified the intervention was not applied for the correct time as prescribed by the PT.

The Physiotherapist (PT) verified the application time of any PT intervention was not to be increased and acknowledged that the therapy was not provided according to the care plan intervention that was in place for the resident.

The Hydrocollator Temperature Log was incomplete. There was no temperature reading documented for the date of the incident and for multiple months before the incident date.

The Novo Peak Health "Description of Duties - Physiotherapist Assistant" states the PTA will "follow all safety precautions and procedures laid out by the supervising Physiotherapist for the protection of both the resident and the PTA". The Physiotherapist stated the statement means the PT implements the care plan and the PTA follows it. The PT explained the PTA would inspect the resident's before, during and after treatment and the PTA should have asked how the resident was feeling; and it would be in the best interest of the resident that the PTA remains with the resident to monitor continuously. Also, the PTAs were to check the temperature of the hydrocollator daily and the safe range should be between 158-165 Fahrenheit (F).

The Novo Peak Health Physiotherapy Policy and Procedure titled "Pre-Treatment Testing for Hot-Cold Sensation" stated, "For safety reasons, the physiotherapist will conduct an evaluation for the temperature sensation of the area to which a thermal modality is to be applied, to ensure that the resident can appreciate the difference between hot and cold." The PT shared the test would have been completed by the PT during the assessment of the resident. The PT stated it was a College of Physiotherapists standard to perform the sensation test if prescribing the specific therapeutic intervention because there have been other unfortunate incidents with injuries. The sensation test however was not documented as part of the resident's care plan. The PT stated a new paper assessment form was created and implemented to capture the specifications of the sensation test.

Based on these observations, interviews and record review, the resident received a specific physiotherapy intervention where the resident sustained injuries. There was no Hydrocollator temperature reading documented for the date of the incident. The care plan for the resident had an intervention that stated the therapy was to be in place for a

specific time and on multiple occasions over two months, the resident received the therapy for intervals longer than prescribed. At the time of the therapy, the PTA did not use a timer to adhere to the prescribed therapy administration times, the resident was not monitored during the application of the therapy, the resident's skin was not assessed before and after the therapy and the resident did not have personal access to a call bell while sitting in the TV area. The resident did not receive immediate treatment and interventions to promote healing and prevent infection as required. A skin observation and pain assessment were not completed and documented on the date of the incident. The resident had an increase in pain related to their injuries. The RPN did not complete the "Referral to Skin Care Lead - SV2" and should have. A Registered Dietitian (RD) referral was sent by the ADNC and the RD assessed the resident six days after the onset of pain and injury. An infection was confirmed at the injury site, and the resident was administered medical management of the infection for multiple weeks.

The licensee failed to ensure that the resident was protected from neglect. There was failure to provide the resident with the therapy as prescribed by the Physiotherapist and the resident sustained injuries that became infected. The resident did not receive immediate treatment and interventions on the date of the incident to promote healing and prevent infection as required. The temperature of the hydrocollator was not checked daily for several months as required and this jeopardized the safety of all residents who received the specific therapeutic intervention. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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. a) The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident.

The current care plan for a resident in Point Click Care (PCC) documented one specific therapeutic intervention provided by physiotherapy.

A progress note in PCC documented that the resident was to receive a second specific therapeutic intervention and the therapy was provided multiple times.

The Physiotherapy Assessment - SV - V 1 did not document both therapies to be provided by physiotherapy.

The Exercise Therapist verified there were no other progress notes by the Physiotherapist related to the second therapy. The Exercise Therapist shared they did not know about the therapy and any new Physiotherapy Assistant (PTA) or Kinesiology student would not know to provide the therapy because it was not a part of the resident's plan of care. The Exercise Therapist verified the written plan of care for the resident did not set out the planned care related to the second therapy; the goals the therapy was intended to achieve; and clear directions to the physiotherapy staff who provided the therapy.

The Physiotherapist (PT) stated the resident's plan of care did not include the application of another specific therapy to a specific region of the resident's body.

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care related another specific therapy; the goals the care was intended to achieve; and clear directions to the physiotherapy staff who provide direct care to the resident.

b) The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The current care plan for a resident in Point Click Care documented the resident was to receive a specific therapeutic intervention, but there were no specific instructions for how long the therapy was to be implemented.

The Physiotherapy Assessment - SV - V 1 documented a treatment plan that identified a therapy intervention, but there were no specific instructions for how long the resident was to receive the therapy.

The Colligo report documented that the resident's therapy was implemented for a specific time.

The Exercise Therapist verified there was no time frame for how long the therapy needed to be applied and there should be since the PTA does not make that decision. The PT's direction should be clear, and the Physiotherapy Assessment did not state a length of time the therapy was applied.

The Physiotherapist (PT) stated the resident's plan of care for the application of the therapy did not include how long the therapy was to be applied. The PT verified that the plan of care did not set out clear directions to the Physiotherapy Assistants who provide the therapy.

The licensee has failed to ensure that the plan of care set out clear directions for the application of the therapy to the physiotherapy staff who provide the direct physiotherapy care to the resident.

2. a) The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The Critical Incident (CI) System Report documented that a resident had an incident for

which the resident was taken to hospital with a significant change in the resident's health status and a confirmed injury.

The current care plan for the resident in PCC documented that the resident had a specific transfer status.

The "Kinesiology Program For Active Living Assessment - SV1 - V 2" was completed by the Exercise Therapist. This was a transfer assessment only and the resident was assessed as a different transfer status than what was documented as part of the care plan.

The resident's room was observed with a logo that indicated the same transfer status as documented in the "Kinesiology Program For Active Living Assessment - SV1 - V 2".

The resident stated they previously had a different transfer status prior to their incident and injury, and their transfer status had been updated.

The Acting Director of Nursing Care stated the current care plan documented the resident was a specific transfer and it did not match the existing transfer status in place for the resident.

The Registered Practical Nurse (RPN) shared that they were familiar with the resident's care and recent incident. The RPN pointed to the transfer logo and said the resident's transfer status changed since the incident. The RPN reviewed the current care plan in PCC for the resident and verified that the care plan was not updated according to the recent assessment related to transfer status. The RPN also verified that the logo posted in the resident's room and the transfer intervention in the resident's care plan did not match.

The Personal Support Worker (PSW) shared that the resident was a specific transfer status for all transfers and verified the resident's transfer status was not clear.

The Exercise Therapist verified that a transfer assessment was completed and the transfer status had changed. The Exercise Therapist stated they changed the transfer logo in the room, but not as part of the resident's PCC care plan and it was a combination between the nursing team and the Exercise Therapist who were responsible for ensuring new interventions were communicated to the team and put in place.

The Schlegel Villages Care Plans Tab 04-20 policy stated, "it is the policy of Schlegel Villages to ensure that resident care plans are prepared, completed, reviewed, and updated with personalized and current resident information."

The licensee failed to ensure that the resident's change in transfer status provided clear direction to staff and others who provided direct care related to transferring the resident.

b) 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.

The Critical Incident (CI) System Report documented that the resident had an incident for which the resident was taken to hospital with a significant change in the resident's health status and a confirmed injury.

The current care plan for the resident in Point Click Care (PCC) documented a specific fall prevention intervention by the Exercise Therapist.

The resident's room was observed, and the specific fall intervention was not in place. The resident stated they did not use the specific fall intervention.

The Registered Practical Nurse (RPN) shared that they were familiar with the resident's care and recent incident. The RPN stated that the resident did not use a specific fall intervention and verified that it was not in place. The RPN reviewed the current care plan for the resident and verified that the specific fall intervention was put in the care plan, but was not in place in the resident's room as planned.

The Acting Director of Nursing Care stated the current care plan documented a specific fall intervention.

The Personal Support Worker (PSW) shared that the resident did not use the specific fall intervention. The PSW shared they were familiar with the resident's care and this was the first time they have heard about the use of the specific fall intervention.

The Exercise Therapist verified that a transfer assessment was completed, and the specific fall intervention was to be implemented. The Exercise Therapist stated it was a combination between the nursing team and the Exercise Therapist who were responsible for ensuring new interventions were communicated to the team and put in place.

The Schlegel Villages Fall Prevention & Management Program [LTC] Tab06-02 stated the registered nursing team was to "consider strategies based on individual risk factors, implement where appropriate and document on the resident's Plan of Care". The neighbourhood team "follow the strategies as outlined in the plan of care." The Exercise Therapist was to "collaborate with neighbourhood teams and share strategies which can be used by the neighbourhood team to promote resident independence and safety."

The licensee failed to ensure that the resident's specific fall intervention set out in the plan of care was provided to the resident as specified in the plan.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment were kept in good repair, maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

In accordance with Ontario Regulation 79/10, s. 90 (1) the licensee was required to ensure "as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance.

The Critical Incident System Report documented the improper/Incompetent treatment of a resident that resulted in harm to the resident. The resident received therapy and sustained injuries. A video teleconference was held with Novo Peak Health representatives regarding the investigation follow up and steps moving forward to prevent recurrence and minimize risk and ensure proper procedures and policies were in place and followed to minimize risk moving forward.

The General Manager stated Novo Peak Health Incorporated (Inc.) was the company that provided physiotherapy and occupational therapy to the residents in the home. The General Manager stated the home emailed Novo Peak with questions about their processes related to the hydrocollator, temperatures, assessment, application, quality assurance and documentation practices. Novo Peak also forwarded policies related to the hydrocollator. The home management team reviewed those policies and discovered that the Physiotherapy Assistants (PTAs) were not complying with their own policies by not checking hydrocollator temperatures and documenting daily. Records were developed to be completed daily and monthly, but these preventative maintenance equipment records were not being completed consistently.

The Novo Peak Health Inc. Executive Vice President Eldercare (EVPE) explained that there was a preventative maintenance program for physiotherapy equipment that included the daily, monthly and annual "Preventative Maintenance Equipment Record" completed by the people using the equipment, which would be the PTA in most cases for daily and monthly auditing. The EVPS stated the Physiotherapist (PT) signs off on the daily records monthly reviewing and verifying the daily preventative records were being completed and signs off on the monthly records at the end of the year. The EVPE stated it was a College of Physiotherapists of Ontario mandated requirement for safety checks and these records need to be kept for five years. The EVPE verified that the daily and monthly preventative maintenance checks were not consistently being completed.

The PTA explained that every morning the PTAs check the temperature of the hydrocollator. The PTA stated the function of a hydrocollator was to heat up the hot packs by using water and the safe temperature range for a hydrocollator was 155-160 Fahrenheit (F) as the usual range, and 160 F was the max. The PTA stated that the

"Hydrocollator Temperature Log" was completed each morning once a day. The Daily Preventative Maintenance Equipment Record was also completed by the PTA and included the hydrocollator.

The Physiotherapist (PT) shared that they have been the PT in the home for a month. The PT explained there were schedules and procedures in place for routine preventive maintenance related to the electrical and non-electrical equipment used by the physiotherapy department that included the completion of daily, monthly and annual "Preventative Maintenance Equipment Record(s)". The PT stated the preventative maintenance was completed to ensure safety standards were up to date and the residents were safe. The PT added that there were gaps where there was no daily record for multiple months in 2019 and there should have been. The monthly audit was missing for two months in 2019. The PT stated it was the PTAs responsibility to complete the daily and monthly preventative records and the PT would then document monthly that the daily audits were done, and this was scanned and emailed to Novo Peak. The annual preventative maintenance record was completed the same way where the monthly records were reviewed by the PT as part of the annual record. The PT stated there was no documented evidence that preventative maintenance was completed as scheduled for equipment used by physio. The PT also verified that the daily hydrocollator temperature readings were not being completed. The PT explained that there were several hot packs heating in the water at one time, the temperature was to be taken for 30-60 seconds and the daily temperature checks confirmed that the dial was set at the right temperature range.

The Novo Peak Health Policy and Procedure titled "Physiotherapy Preventative Maintenance for Equipment" stated, "It is the responsibility of each physiotherapist to ensure that all equipment is safe for use and that regular checks of equipment are performed. The frequency, with which the equipment must be verified (annually, monthly or daily), depends on its inherent risk to the resident. The forms of reference are called Daily/Monthly/Annual Preventative Maintenance Equipment Record." "Daily – Hydrocollator temperature is in safe range (71-74 C, 160-166 F)" and monthly the hydrocollator was to be emptied and cleaned.

The Novo Peak Health Policy and Procedure titled "Hydrocollator Heating Units Standards of Operations and Care" stated, "Before using a hot pack, ensure that the water temperature is in the recommended operating range of 160 – 166 F".

The Daily Preventative Maintenance Equipment Records were not completed multiple

months in 2019. The daily maintenance records for multiple months in 2019 were missing the PT signature as reviewed. The Monthly Preventative Maintenance Equipment Records were not completed for two months in 2019. The preventative maintenance records were not implemented as scheduled daily and monthly for routine, preventive and remedial maintenance of the electrical and non-electrical equipment used by the physiotherapy staff.

The Hydrocollator Temperature Log was completed on two dates in January 2019. The next documented date was in June 2019. There was missing documentation between January and June 2019.

The licensee failed to ensure that procedures developed were implemented to ensure that electrical and non-electrical equipment used by physiotherapy were kept in good repair, maintained and cleaned. [s. 90. (2) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment were kept in good repair, maintained and cleaned at a level that meets manufacturer specifications, at a minimum., to be implemented voluntarily.***

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**Issued on this 6th day of September, 2019**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et 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 Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

**Public Copy/Copie du public**

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MELANIE NORTHEY (563) |
| **Inspection No. / No de l'inspection :** | 2019_778563_0030 |
| **Log No. / No de registre :** | 012799-19, 015320-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 6, 2019 |
| **Licensee / Titulaire de permis :** | Schlegel Villages Inc.<br>325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5 |
| **LTC Home / Foyer de SLD :** | The Village of Glendale Crossing<br>3030 Singleton Avenue, LONDON, ON, N6L-0B6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Cindy Awde |

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / Ordre no :** 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

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

Specifically, the licensee must:
a) Ensure the resident and any other resident is assessed to determine if hot pack therapy is appropriate taking into consideration the resident's cognitive and physical limitations.
b) Ensure the Physiotherapist will conduct an evaluation for the temperature sensation of the area to which a thermal modality is to be applied to ensure that the resident and any other resident can appreciate the difference between hot and cold. There must be a documented record of the pre-treatment testing for hot-cold sensation.
c) Ensure the resident and any other resident's plan of care sets out clear directions for the application of hot pack therapy to the physiotherapy staff who provide the direct physiotherapy care to the resident.
d) Ensure before using a hot pack that the hydrocollator water temperature is in the recommended operation range of 160 Fahrenheit (F) – 166 F and document the temperature of the hydrocollator.
e) Ensure the resident and any other resident's skin is assessed before and after the application of the hot pack and the resident is monitored during the application of the hot pack.
f) Ensure the resident and any other resident's hot pack therapy is applied for the correct time as prescribed by the Physiotherapist.
g) Ensure that at the time of the hot pack therapy a timer is used to adhere to the prescribed hot pack therapy administration times.
h) Ensure the Physiotherapy Assistants understand the guidelines and expectations associated with hot pack therapy.

**Grounds / Motifs :**

1. The licensee failed to ensure that a resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

The Critical Incident System report documented an incident where a resident sustained multiple injuries. The family member also wished to file a formal complaint.

The Schlegel Villages Resident/Family Complaint Response Form documented a reported concern from the resident's family member related to the resident's injuries. There was a meeting with the family and the home's management to discuss the possibility that the resident's injuries were after the administration of a specific therapeutic intervention.

The home's investigation notes included an interview with the Registered Practical Nurse (RPN) on shift the date of the incident. The RPN did not complete a documented weekly skin observation or a Pain Assessment in Advanced Dementia Scale (PAINAD) in Point Click Care (PCC). A referral to the Skin and Wound Lead and the Registered Dietitian was not completed in PCC. The interview documented that the RPN forgot to implement the physician's orders to treat the resident's injuries and the physician's order was not documented as part of the resident's Treatment Administration Record (TAR) for three days.

The TAR Schedule documented an order for the resident to receive treatment for their injuries. There was no documented administration of a treatment in the TAR for three days after the incident. A communication progress note in PCC documented the treatment was provided the next day. There should have been immediate treatment and interventions to promote healing and prevent infection as required.

The General Manager (GM) and Acting Director of Nursing Care (DNC) stated

they believed the the injuries to the resident was a result of the administration of a specific therapeutic intervention. The GM stated they emailed Novo Peak Health with questions related to their processes related to the hydrocollator, temperatures, assessments, application, quality assurance and documentation of therapy. Novo Peak Health Incorporated was the company that provided physiotherapy and occupational therapy to the residents in the home. The DNC stated the Physiotherapist Assistants (PTAs) were not documenting in PCC like they should have been and the expectation and agreement with Novo Peak was that the documentation was to be completed in PCC related to the therapy provided. The GM stated a report was sent from Novo Peak to the home that documented their investigation. The GM shared that the discrepancies with the home's investigation prompted escalation to the support office and the Director of Purchasing, the Director of Operations, the Vice President of Support Office Services, and the Head Nurse Consultant for Schlegel Villages.

The Novo Peak "Family Concern at The Village of Glendale Crossing Submitted by Executive Vice President (VP) – Eldercare" was emailed to the General Manager. The data gathering identified that a Physiotherapy Assistant (PTA) had not consistently checked the resident's skin integrity before and after the application of a specific therapy, the therapy had been implemented for varying intervals of time, and the temperature verification of the hydrocollator was not consistently measured on each day of use as required.

A written statement was provided by the PTA explained the events involving the resident. The PTA provided the specific therapeutic intervention in the television (TV) room and then left the resident to see another resident in the same neighbourhood. Once the other resident's physiotherapy program was finished after 15 minutes, the PTA returned to remove the intervention from the resident. The resident was found in their room in bed and the PTA noted the therapeutic intervention was removed. A timer was not used to adhere to the prescribed therapy administration times, the resident was not monitored during the therapy and the resident was not assessed before and after the therapy. The resident did not have personal access to a call bell while sitting in the TV area should the therapy require removal. The PTA's written statement stated it was unusual to see the resident in bed during the day, but there was no follow up with the nursing team members regarding this change.

A written statement by the Personal Support Worker (PSW) documented that the resident was found in their room with a therapeutic intervention in place. The PSW removed it and the resident was transferred back to bed by two PSWs.

One of the PSWs stated they were familiar with the care of the resident and could recall the incident. The PSW stated the resident was in their room and was observed with the specific therapeutic intervention in place. The PSW shared, to the best of their memory, that the resident was transferred back to bed as this was the typical routine. The PSW stated the specific therapeutic intervention was placed on top of the resident's pants. The PSW remembered the therapy was removed and the resident was transferred back to bed with two staff. There was no PTA in the room and the resident did not seem to be in pain or discomfort at that time. The PSW also shared there have been several times where the PSWs would go into the residents' rooms and there would be the specific therapy in place and the PSWs would not know when it was applied or how long it had been there; and sometimes the residents would be in the common area with the specific therapy in place with no PTA present.

The Novo Peak Health Physiotherapy Policy and Procedure stated, "Observe the skin of the area to be treated prior to beginning to ensure it is intact". The policy instructed to "provide a call bell so that the resident can ring should they require assistance" and "observe the skin".

The Pain Assessment in Advanced Dementia Scale (PAINAD) Extension-SV assessment was completed and documented in PCC by the RPN eight days after the incident.

The Schlegel Villages Pain Management Program Tab 04-48 described pain as "an unpleasant subjective experience that can be communicated to others through self-report when possible and/or a set of pain-related behaviours; it is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." The Registered Team were to complete and document a pain assessment in PCC "when there are personal expressions exhibited by resident that may be an indicator for the onset of pain" or "when there is a change in condition with pain onset" or "when report from resident, family, team member volunteers that pain is present". According to the home's pain management program, the resident was to be assessed the

day of the incident when the injury caused pain.

The TAR and physician's order to treat a specific area was not updated to reflect other areas of injury identified. The Assistant Director of Care (ADNC) completed a skin assessment and initiated a new order and completed the first documented PAINAD assessment since the incident. A Dietitian Referral was also sent by the ADNC and the Registered Dietitian (RD) assessed the resident six days after the onset of pain and injury. Also, there was a new intervention to hold the therapeutic intervention.

The Weekly Skin Observation Tool - SV2 - V 2 assessment was completed and documented in PCC by the RPN eight days after the incident.

Approximately 14 days after the incident the resident continued to have increased pain, had acquired wound infections and was no longer receiving physiotherapy exercises that proved effective. The physician had increased pain management medications and the route for administration.

The scheduled treatment for a new specialized intervention was not scheduled as part of the TAR, therefore there was no schedule attached to the order to flag the nurses to administer the treatment at the prescribed times. The ADNC stated the nurse would not know that the treatment was due and there was no documentation when the treatment was last administered. There was no documented evidence that the treatment was implemented as ordered by the physician.

The resident then sustained another injury during care and there was no documented evidence that the resident's acting Power of Attorney (POA) was informed of the injury. There was no TAR documentation or progress note to state that the resident received the treatment to the new injured area on two separate dates as prescribed. The resident was also administered an inappropriate treatment intervention to their original injury that was not prescribed. There was no weekly skin observation completed in PCC for 11 days.

The Assistant Director of Nursing care (ADNC) stated the RPN observed the resident's skin and received the physician's order, started the treatment but did

not enter the order in the Treatment Administration Record (TAR) on the date of the incident. The ADNC could not provide documented evidence of the type of treatment started immediately and stated the "Referral to Skin Care Lead - SV2" should have been completed the day the injury was identified. The ADNC shared that the referral would remind the registered nursing team to complete the following:
- Type of Skin Issue,
- Description and treatment used (if applicable),
- Treatment added to TAR (date and time),
- Weekly Skin Observation Tool implemented (date and time),
- Resident/SDM Notified (date and time),
- Physician Notified (date and time), and
- Referral to Dietician completed (date and time).

The ADNC verified that if the RPN completed the "Referral to Skin Care Lead - SV2" as outlined in the "Process of New Skin Concerns" they would have been reminded to also complete a TAR, a skin observation assessment in PCC, a PAINAD and referral to the RD and this was not completed.

The Schlegel Villages Treatment Records tab 05-40 stated, “treatments are arranged in the treatment record” and “once the treatment is completed, all treatments will be signed on the Treatment Administration record (TAR) by the team member completing the treatment.” The new specialized treatment intervention was not documented as administered because it was never arranged as a treatment record.

The Remedy’s Rx Documentation of orders Policy No. 4.8 last revised August 15, 2018 stated, “As soon as possible after receiving the order, the registered staff check the order for completeness” and transcribe to the administration record.

The Schlegel Villages Skin and Wound Care Program Tab 04-78 stated the Registered Nurse and Registered Practical Nurse “communicates with resident and/or substitute decision maker, and the Village team regarding skin and wound issues” and “completes pain assessment as appropriate”. The skin and wound program instructs the registered team members to assess altered skin integrity including skin breakdown and to refer to the Dietitian using the Dietitian referral form. “The registered team member will conduct an assessment and

document that assessment" in PCC "when there is a change in skin integrity and weekly thereafter until it is healed." The Personal Support Workers "reports and documents abnormal or unusual skin concerns to the registered nursing team member, including but not limited to red or open areas, blisters, bruises, tears, scratches."

The home's skin and wound program included specific guidelines for assessment, interdisciplinary follow up and documentation. The registered staff failed to follow the "Process of New Skin Concerns" in providing the resident with the care and treatment immediately after the discovery of their injuries.

At the time of the incident, the care plan for the resident in PCC documented a specific therapeutic intervention to be administered for a specific amount of time. The Physiotherapist Assistant would implement the interventions as part of the resident's plan of care and would document the therapy in Colligo. The Colligo report had a "minutes" column which represented the amount of time the Physiotherapy Assistant spent preparing for the administration of the therapy. The "supervised" column indicated the direct time the therapy was applied.

The Colligo report documented that 69 per cent of the time the resident was provided the intervention for a longer period than prescribed by the Physiotherapist. On the date of the incident the resident received the therapy for twice as long as prescribed by the Physiotherapist.

The Exercise Therapist (ET) verified a PTA can not adjust the implementation of an intervention ordered by the Physiotherapist (PT). The ET stated the PTAs were never to increase the application time and verified the intervention was not applied for the correct time as prescribed by the PT.

The Physiotherapist (PT) verified the application time of any PT intervention was not to be increased and acknowledged that the therapy was not provided according to the care plan intervention that was in place for the resident.

The Hydrocollator Temperature Log was incomplete. There was no temperature reading documented for the date of the incident and for multiple months before the incident date.

The Novo Peak Health "Description of Duties - Physiotherapist Assistant" states the PTA will "follow all safety precautions and procedures laid out by the supervising Physiotherapist for the protection of both the resident and the PTA". The Physiotherapist stated the statement means the PT implements the care plan and the PTA follows it. The PT explained the PTA would inspect the resident's before, during and after treatment and the PTA should have asked how the resident was feeling; and it would be in the best interest of the resident that the PTA remains with the resident to monitor continuously. Also, the PTAs were to check the temperature of the hydrocollator daily and the safe range should be between 158-165 Fahrenheit (F).

The Novo Peak Health Physiotherapy Policy and Procedure titled "Pre-Treatment Testing for Hot-Cold Sensation" stated, "For safety reasons, the physiotherapist will conduct an evaluation for the temperature sensation of the area to which a thermal modality is to be applied, to ensure that the resident can appreciate the difference between hot and cold." The PT shared the test would have been completed by the PT during the assessment of the resident. The PT stated it was a College of Physiotherapists standard to perform the sensation test if prescribing the specific therapeutic intervention because there have been other unfortunate incidents with injuries. The sensation test however was not documented as part of the resident's care plan. The PT stated a new paper assessment form was created and implemented to capture the specifications of the sensation test.

Based on these observations, interviews and record review, the resident received a specific physiotherapy intervention where the resident sustained injuries. There was no Hydrocollator temperature reading documented for the date of the incident. The care plan for the resident had an intervention that stated the therapy was to be in place for a specific time and on multiple occasions over two months, the resident received the therapy for intervals longer than prescribed. At the time of the therapy, the PTA did not use a timer to adhere to the prescribed therapy administration times, the resident was not monitored during the application of the therapy, the resident's skin was not assessed before and after the therapy and the resident did not have personal access to a call bell while sitting in the TV area. The resident did not receive immediate treatment and interventions to promote healing and prevent infection as required. A skin observation and pain assessment were not completed and

documented on the date of the incident. The resident had an increase in pain related to their injuries. The RPN did not complete the "Referral to Skin Care Lead - SV2" and should have. A Registered Dietitian (RD) referral was sent by the ADNC and the RD assessed the resident six days after the onset of pain and injury. An infection was confirmed at the injury site, and the resident was administered medical management of the infection for multiple weeks.

The licensee failed to ensure that the resident was protected from neglect. There was failure to provide the resident with the therapy as prescribed by the Physiotherapist and the resident sustained injuries that became infected. The resident did not receive immediate treatment and interventions on the date of the incident to promote healing and prevent infection as required. The temperature of the hydrocollator was not checked daily for several months as required and this jeopardized the safety of all residents who received the specific therapeutic intervention.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was related to 1 out of 3 residents reviewed. The home had a level 4 history as the home had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued May 5, 2017 (2017_538144_0009);
- WN and VPC issued August 25, 2017 (2017_263524_0018);
- WN and VPC issued September 12, 2017 (2017_263524_0017);
- WN and Compliance Order (CO) issued September 12, 2017 (2017_607523_0007). The CO was complied February 7, 2018 (2018_262630_0003);
- WN issued February 9, 2018 (2018_262630_0004);
- WN and CO issued September 14, 2018 (2018_606563_0013). The CO was complied January 14, 2019 (2019_263524_0001) (563)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Sep 27, 2019

## 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 6th day of September, 2019**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Melanie Northey

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