Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 14, 2022	2022_861194_0005 (A2)	021152-21, 002589-22	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care on McLaughlin Road
114 McLaughlin Road Lindsay ON K9V 6L1

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

Amended by CHANTAL LAFRENIERE (194) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's compliance due dates related to CO# 002, CO# 003, CO# 004 and CO#005 will be extended at the homes request from June 10, 2022 to July 10, 2022.

Issued on this 14th day of June, 2022 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by CHANTAL LAFRENIERE (194) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 28, 29, 30, 31, 2022 on site, April 4, 5, 6, 7, 8, 2022 off site

The inspector inspected a complaint related to resident care, operation of the home and a Critical Incident report for COVID-19 Outbreak.

During the course of the inspection, the inspector(s) spoke with residents, SDM of identified residents, Director of Operations, Regional Director of Operations, Executive Director, Acting Director of Care (Acting DOC), Acting Assistant Director of Care (Acting ADOC), IPAC nurse from Ross Memorial, IPAC Manager from Ross Memorial, Public Health Nurse, Environmental Services Manager, (ESM) COVID-19 Screener/Tester, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping staff and Dietary Aide.

During the course of the inspection, the Inspector completed a tour the building, observed infection prevention and control practices, air temperatures, provision of staff to resident care. The inspector reviewed communication from Family Council, complaint logs, air temperature logs, preventative maintenance records, clinical health records for identified residents, staff educational records and medication incident records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1.The licensee failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

A concern related to air temperatures was forwarded to the management of the home. The Administrator and ESM confirmed that the repairs were completed.

A Housekeeper (HSKP) confirmed that the air temperatures had been below the 22 degrees celsius at times, prior to the repairs being completed.

Air temperature was taken in a dining room by Inspector #194 and noted to be below 22 degrees celsius. A dietary aide confirmed that the room was cool and that the two heaters visible on the floor would be plugged in, before residents entered.

Two residents confirmed their room were too cold in the winter. The residents stated that the air temperature now, was more comfortable. The residents confirmed that during the winter months, there was no heat coming from their heat registers.

Air Temperature logs at the home indicated several temperature readings below 22 degrees Celsius in the home. There were no follow up actions documented on the air temperature logs for any of the temperature readings below 22 degrees.

The Hepa Filters were noted with air temperature readings below 22 degrees on three separate incidents.

Failing to ensure that the home is maintained at a minimum of 22 degrees Celsius, impacts the residents comfort.

Source: Maintenance records, air temperature logs, interviews with residents and staff. [s. 21.]

2. The licensee failed to ensure that temperatures required to be measured under subsection (2) documented at least once every morning, once every afternoon and between 12 pm and 5 pm and once every evening or night.

ESM stated that the air temperatures were taken by housekeeping staff (HSKP). The ESM confirmed that they were responsible for reviewing the air temperature logs. The ESM stated that they were not aware of the missing dates and times or of the air temperatures that were below the 22 degrees identified on the logs.

A HSKP confirmed that the air temperatures had been below the 22 degrees Celsius at times prior to the repairs being completed and that ESM had been informed.

Air Temperature logs for the Month of March 2022 confirmed that there were several temperature readings that had not been measured or documented.

Failing to ensure that the air temperatures were measured and documented at the required intervals, increases the risk of air temperatures to be out of the required range, negatively impacting residents' comfort.

Source: Air temperature logs and interview with staff. [s. 21. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident’s health.

An SDM confirmed that there had been a near miss with a resident, where the resident had almost been provided with incorrect medications. The SDM reported the near miss to the DOC along with additional information that on the same date, the resident had not been provided their medications until three hours after the prescribed time.

There were no medication incident reports completed for either of the medication incidents.

Failing to ensure that every medication incident involving a resident and every

adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, increases the risk for further medication incidents at the home.

Source: Medication Incident reports, interview with staff and SDM. [s. 135. (1)]

2. The licensee failed to ensure that in addition to O. Reg 79/10 s. 135(1)(a) corrective action is taken as necessary.

There were two medication incidents involving the same resident, one incident had corrective actions of monitoring the resident for 72 hours and only one assessment was completed. The other medication incident required corrective action of assessments to be completed every 30 minutes for a specified period of time and only two assessments were completed.

Inspector #194 reviewed the medication incident reports and was unable to verify who were the registered staff responsible for the incidents and what corrective action were taken to prevent reoccurrence.

The Executive Director (ED) confirmed that they had spoken to the charge nurse involved in one of the medication incidents. The resident was started on a 72-hour observation period. The residents progress notes confirmed one assessment was completed during the 72-hour observation period.

Review of the second medication incident was completed. The physician directed, assessments to be completed every 30 min while awake and when sleeping to assess every 3 hours

Review of the clinical health records indicated that only two assessments were completed in a 90 min period.

Failing to ensure that corrective action is taken, following a medication incident, related to 72-hour monitoring, and every 30-minute assessments, increases the risk of harm to the resident.

Source: Medication incident report, Clinical health records for resident, and interview with staff. [s. 135. (2)]

Additional Required Actions:

CO # - 002, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002,004

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the Infection Prevention and Control Program.

An RN confirmed that a resident was on additional precautions. Observation of the room indicated no additional precaution signage. Another RN confirmed the resident was on additional precautions, stating that the resident was probably out of isolation. A few days later, the resident fell and a PSW confirmed that the resident had been placed on isolation, upon return from the hospital. The PSW stated that they applied all PPEs when entering the resident's room because that there were no signs to indicate the type of additional precautions were required.

Another resident room was observed with a PPE caddy outside the resident's room with no masks or eye protection. There was no additional precaution signage outside the room. A PSW and RN confirmed that the resident was on

additional precautions.

Another resident was observed to have additional precaution sign outside their room, with no PPEs caddy. Two PSWs were observed leaving the room not wearing any PPE's. When asked the PSWs confirmed that the additional precautions had been discontinued, three days previously.

Another resident was observed with a PPE caddy with no gowns and no signage for additional precaution. An RPN confirmed that the resident was under additional precaution. The plan of care for the resident confirmed that the resident was under additional precautions and that staff should be wearing gown and gloves.

Another resident was observed with a PPE caddy. There was no additional precaution signage outside the resident's room. The plan of care for the resident confirmed that the resident was under additional precaution.

Review of an IPAC audit completed by a third party, indicated that the home did not have the appropriate additional precautions signage in place during the recent outbreak.

Failing to ensure that additional precaution signage was posted, increases the potential spread of infection.

Source: observation of the home areas, clinical health records, interview with staff [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
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 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 :

1. The licensee failed to ensure that the training required under section 76 of the Act must be provided, (a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 76 (2) of the Act.

1.The Residents' Bill of Rights
3.The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control

Interviews with Acting DOC and Acting ADOC confirmed that the home had hired many new staff and they had not been provided with the required education.

A review of the educational records and interview with several, registered nursing staff, confirmed that the required education was not provided within 10 days of performing their duties.

Failing to ensure that staff are provided with required education prior to starting their duties, jeopardizes resident safety.

Source: Review of SURGE Learning Records and interview with staff. [s. 76. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of this or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint from Family Council was received related to the provision of bed baths during the outbreak.

Inspector #194 was informed by Acting DOC and Acting ADOC, that the direction for discontinuation of bathing in the tub room at the home during the outbreak came from Public Health.

A Public Health Nurse confirmed that the Public Health Unit had not provided the Home with any direction to discontinue bathing of residents in the tub room, during the outbreak.

IPAC representative from a Third Party, confirmed that there was no communication related to the discontinuation of baths at the home during the recent outbreak.

IPAC representative from a Third Party, confirmed that they had been involved with home at the onset of the outbreak. IPAC lead confirmed that they completed an IPAC Audit, with some concerns reported, documented, and provided to the home regarding IPAC practices at the home. IPAC Lead confirmed that at no time was there any discussion with them related to the bathing practices at the home

A resident confirmed that during the outbreak they were provided with bed baths, and staff were using shower caps. Resident stated that they would have preferred a bath and to have their hair washed in the tub. The plan of care for resident indicated that they preferred a bath. Review of the bathing records confirmed that the resident received bed baths during the reviewed period.

The SDM for a resident confirmed that the resident received bed baths, during the recent outbreak. SDM stated that tub baths would have been preferred and that the resident's hair could have been washed during the bathing process. The plan of care for resident indicated that they preferred a bath. Review of the bathing records confirmed that the resident received bed baths, for the reviewed period.

Another resident confirmed receiving bed baths during the recent outbreak but would have preferred their tub bath. The plan of care for resident indicated that they preferred a bath.

Failing to ensure that residents are bathed, twice weekly, by the method of their choice, decreases the quality of life for the resident.

Source: Clinical health records for residents, interview with IPAC representatives from third party and residents. [s. 33. (1)]

Additional Required Actions:

CO # - 006 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# 006

WN #6: 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 failed to ensure that the where the 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 in complied with.

-the licensee shall ensure that there is a hand hygiene program in place.

-The licensee shall ensure that there is in place a written plan for responding to infectious disease outbreaks.

Management of COVID-19 – staff roles and responsibilities directed that the Infection Control Lead will monitor active illness screening records and daily resident surveillance records for infections including respiratory illnesses, typical and atypical signs and symptoms that may be linked to COVID-19.

The licensee's hand Hygiene policy dated September 20, 2022, directed that hand staff were to complete hand hygiene before handling or serving of food or medications to residents.

-hands of residents, staff, volunteers, or family members are to be cleaned before assisting with meals or snacks.

PSW's were observed providing the nourishment cart. There was no hand

hygiene noted to be offered to the residents and no hand hygiene noted by staff between residents during the nourishment pass. A PSW confirmed that they usually provide hand hygiene during nourishment pass and were not able to explain why it was not completed today.

Acting DOC has stated that the documentation for the recent outbreak, was not available.

Failing to ensure that hand hygiene is performed during the nourishment pass for the resident and staff, increases the spread of infection.

Failing to ensure that the homes records related to an outbreak are kept and available, has little impact on the resident.

Source: Observation of a nourishment pass, review of policy for hand hygiene, Review of Management of COVID-19 staff roles and responsibilities, interview with staff. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

A letter of concern from the Substitute Decision Maker (SDM) of a resident, was provided to the DOC outlining concerns related to the resident's personal care. The Acting DOC was not able to speak to the management of this complaint.

A complaint form for the incident, involving the resident had been initiated and documented in the home's complaint binder.

Telephone interview with current ED confirmed that the complaint letter had not been forwarded to the MOLTC.

Failing to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director, has minimal impact on the resident.

Source: Review of the Complaint Binder, complaint letter, interview with staff [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that a written complaint concerning the care of a resident is immediately forwarded to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council Advice related to concerns or recommendations.

A letter expressing concerns at the home from the Family Council was forwarded to Caressant Care Corporation.

Director of Operations and Regional Director of Operations confirmed that a written response was not provided to the Family Council within 10 days.

The Acting ED confirmed that multiple telephone conversations and a video call was completed to address the Family Council concerns and a written response was not provided to the Family Council within 10 days.

Failing to ensure that a written response within 10 days of receiving Family Council Advice related to concerns or recommendations, is completed diminishes the communication between Family Council and management of the home.

Sources: Communication between the home and Family Council, interview with representative of the home. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring to respond in writing within 10 days of receiving Family Council Advice related to concerns or recommendations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to ensure that the home carried out every operational or policy directive that applies to the long-term care home.

-Daily Symptom Screening of All Residents. Homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks. • Any resident who presents with signs or symptoms of COVID-19 must be immediately isolated, placed on additional precautions, and tested for COVID-19 as per the COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge, effective March 9, 2022, or as current.

- Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID 19 Updated: December 15, 2021, directs that if the screeners are unable to maintain spatial distance of at least 2 m or separation by physical barrier: Medical mask, Isolation gown, Gloves, Eye protection is required.

Acting DOC confirmed that a number or residents had not been screened for COVID-19. Review of the homes documentation, for a specific period related to daily COVID-19 screening of residents indicated that residents had not been screened for COVID-19 during the reviewed period.

An RN confirmed that residents were not receiving daily COVID-19 surveillance at the home and had not been provided with surveillance since the beginning of the year.

An RPN confirmed that the daily COVID-19 surveillance for residents were no longer being completed, since the end of the outbreak.

Public Health Nurse confirmed that COVID-19 screeners were to be wearing eye protection if not behind plexi glass, and that the COVID-19 testers were to be

wearing eye protection along with other PPEs when completing the COVID-19 testing of staff and visitors in the home.

A COVID-19 screener was observed screening a visitor outside the plexi glass surround, with no eye protection, as well as completing a Rapid Antigen test for visitor without eye protection in place. The COVID-19 screener confirmed that they had been advised through Signage posted on Plexi glass, that visitors were no longer required to wear eye protection while in the home. The COVID-19 screener confirmed that this was in place for themselves as well.

Failing to ensure that operational or policy directive that applies to the long-term care home related to daily COVID-19 screening and appropriate PPE for screening and testing, increases the potential for the spread of infection.

Source: Observation of the COVID-19 screening and testing, Review of the DOCIT documentation and interview with staff. [s. 174.1 (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring to carry out every operational or policy directive that applies to the long-term care home., to be implemented voluntarily.

Issued on this 14th day of June, 2022 (A2)

[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 CHANTAL LAFRENIERE (194) - (A2)
Inspection No. / No de l'inspection :	2022_861194_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021152-21, 002589-22 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 14, 2022(A2)
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care on McLaughlin Road 114 McLaughlin Road, Lindsay, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Croft

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 Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Air temperature

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 21

Specifically the licensee must ensure that:

- The home is maintained at a minimum of 22 degrees celsius.

- Air Temperature logs are to reviewed daily with action taken and documented for all temperatures below 22 degrees celsius, and continue monitoring until temperature is consistency maintained at a minimum of 22 degrees Celsius.

- Re-education to be provided for ESM related to actions taken when Air temperatures are below 22 degrees celsius or above 26 degrees celsius in the home. Keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

A concern related to air temperatures was forwarded to the management of the home. The Administrator and ESM confirmed that the repairs were completed.

A Housekeeper (HSKP) confirmed that the air temperatures had been below the 22 degrees celsius at times, prior to the repairs being completed.

Air temperature was taken in a dining room by Inspector #194 and noted to be below 22 degrees celsius. A dietary aide confirmed that the room was cool and that the two

heaters visible on the floor would be plugged in, before residents entered.

Two residents confirmed their room were too cold in the winter. The residents stated that the air temperature now, was more comfortable. The residents confirmed that during the winter months, there was no heat coming from their heat registers.

Air Temperature logs at the home indicated several temperature readings below 22 degrees Celsius in the home. There were no follow up actions documented on the air temperature logs for any of the temperature readings below 22 degrees.

The Hepa Filters were noted with air temperature readings below 22 degrees on three separate incidents.

Failing to ensure that the home is maintained at a minimum of 22 degrees Celsius, impacts the residents comfort.

Source: Maintenance records, air temperature logs, interviews with residents and staff. [s. 21.]

The licensee failed to ensure that temperatures required to be measured under subsection (2) documented at least once every morning, once every afternoon and between 12 pm and 5 pm and once every evening or night.

ESM stated that the air temperatures were taken by housekeeping staff (HSKP). The ESM confirmed that they were responsible for reviewing the air temperature logs. The ESM stated that they were not aware of the missing dates and times or of the air temperatures that were below the 22 degrees identified on the logs.

A HSKP confirmed that the air temperatures had been below the 22 degrees Celsius at times prior to repairs being completed and that ESM had been informed.

Air Temperature logs for the Month of March 2022 confirmed that there were several temperature readings that had not been measured or documented.

Failing to ensure that the air temperatures were measured and documented at the required intervals, increases the risk of air temperatures to be out of the required range, negatively impacting residents' comfort.

Source: Air temperature logs and interview with staff. [s. 21. (3)]

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

Severity: There was minimal harm to the residents.

Scope: The scope was widespread, with air temperatures below 22 degrees in all units in the home.

Compliance History: There was a no previous compliance.(194) (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 09, 2022

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 :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 135(1)

Specifically the licensee must ensure that:

- All near miss medication incident are documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

- All medication incidents are documented, together with a record of the immediate actions taken to assess and maintain the resident's health .

- Re-education for registered staff, including agency registered staff on the process of reporting and completing a medication incident. Keep a documented record of what education was provided and staff sign off that the education was completed.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident’s health.

An SDM confirmed that there had been a near miss with a resident, where the resident had almost been provided with incorrect medications. The SDM reported the near miss to the DOC along with additional information that on the same date, the resident had not been provided their medications until three hours after the prescribed time.

There were no medication incident reports completed for either of the medication incidents.

Failing to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident’s health, increases the risk for further medication incidents at the home.

Source: Medication Incident reports, interview with staff and SDM. [s. 135. (1)]

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

Severity: There was actual risk to the resident.

Scope: There was a pattern of medication errors, not documented.

Compliance History: There was a previous VPC issued in December 2019 under the same section.(194)
(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 10, 2022(A2)

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: 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 229(4)

Specifically the licensee must ensure that:

- Appropriate additional precautions signs are posted.

- PPEs required for additional precautions are available for staff outside the residents room.

- Re-education for registered staff, including agency staff related to use of appropriate additional precaution signage. Keep a documented record of what education was provided and staff sign off that the education was completed.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participated in the Infection Prevention and Control Program.

An RN confirmed that a resident was on additional precautions. Observation of the room indicated no additional precaution signage. Another RN confirmed the resident was on additional precautions, stating that the resident was probably out of isolation. A few days later, the resident fell and a PSW confirmed that the resident had been placed on isolation, upon return from the hospital. The PSW stated that they applied all PPEs when entering the resident's room because that there were no signs to indicate the type of additional precautions were required.

Another resident room was observed with a PPE caddy outside the resident's room with no masks or eye protection. There was no additional precaution signage outside the room. A PSW and RN confirmed that the resident was on additional precautions.

Another resident was observed to have additional precaution sign outside their room, with no PPEs caddy. Two PSWs were observed leaving the room not wearing any PPE's. When asked the PSWs confirmed that the additional precautions had been discontinued, three days previously.

Another resident was observed with a PPE caddy with no gowns and no signage for additional precaution. An RPN confirmed that the resident was under additional precaution. The plan of care for the resident confirmed that the resident was under additional precautions and that staff should be wearing gown and gloves.

Another resident was observed with a PPE caddy. There was no additional precaution signage outside the resident's room. The plan of care for the resident confirmed that the resident was under additional precaution.

Review of an IPAC audit completed by a third party, indicated that the home did not have the appropriate additional precautions signage in place during the recent outbreak.

Failing to ensure that additional precaution signage was posted, increases the potential spread of infection.

Source: observation of the home areas, clinical health records, interview with staff [s. 229. (4)]

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

Severity: There was actual risk of harm to the residents when IPAC practices were not implemented.

Scope: The scope was a pattern as it involved residents in additional precautions.

Compliance History: A Compliance Order was issued February 2021 and

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

VPC's issued November 2020 and August 2020

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 10, 2022(A2)

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: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 135(2)

Specifically the licensee must ensure that:

- Action are taken as necessary related to all medication incidents.

- Re-education of all registered staff, including agency staff, related to carrying out actions, as a result of medication incidents. Keep a documented record of what education was provided and staff sign off that the education was completed.

Grounds / Motifs :

1. The licensee failed to ensure that in addition to O. Reg 79/10 s. 135(1)(a) corrective action is taken as necessary.

There were two medication incidents involving the same resident, one incident had corrective actions of monitoring the resident for 72 hours and only one assessment was completed. The other medication incident required corrective action of assessments to be completed every 30 minutes for a specified period of time and only two assessments were completed.

Inspector #194 reviewed the medication incident reports and was unable to verify who were the registered staff responsible for the incidents and what corrective action were taken to prevent reoccurrence.

The Executive Director (ED) confirmed that they had spoken to the charge nurse involved in one of the medication incidents. The resident was started on a 72-hour observation period. The residents progress notes confirmed one assessment was completed during the 72-hour observation period.

Review of the second medication incident was completed. The physician directed, assessments to be completed every 30 min while awake and when sleeping to assess every 3 hours

Review of the clinical health records indicated that only two assessments were completed in a 90 min period.

Failing to ensure that corrective action is taken, following a medication incident, related to 72-hour monitoring, and every 30-minute assessments, increases the risk of harm to the resident.

Source: Medication incident report, Clinical health records for resident, and interview with staff. [s. 135. (2)]

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

Severity: There was actual risk to the residents.

Scope: There was a pattern of actions not taken, as a result of the medication incident.

Compliance History: There was a previous non compliance, VPC issued in December 2019 under
the same section. (194)
(194)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 10, 2022(A2)

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: 005

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 LTCHA, 2007, 76(2)

Specifically the Licensee must ensure that:

- All staff, including agency staff have completed education, within one week of performing their responsibilities, the following:
 -The Residents' Bill of Rights
 -The home's policy to promote zero tolerance of abuse and neglect of residents
 -The duty to make mandatory reports under section 24
 -Fire prevention and safety
 -Emergency and evacuation procedures
 -Infection prevention and control
-Keep a documented record of what education was provided and staff sign off that the education was completed.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

1. The licensee failed to ensure that the training required under section 76 of the Act must be provided, (a) within one week of when the person begins performing their responsibilities, with respect to the matters set out in paragraphs 1, 3, 4, 7, 8 and 9 of subsection 76 (2) of the Act.

1.The Residents' Bill of Rights
3.The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control

Interviews with Acting DOC and Acting ADOC confirmed that the home had hired many new staff and they had not been provided with the required education.

A review of the educational records and interview with several, registered nursing staff, confirmed that the required education was not provided within 10 days of performing their duties.

Failing to ensure that staff are provided with required education prior to starting their duties, jeopardizes resident safety.

Source: Review of SURGE Learning Records and interview with staff. [s. 76. (2)]

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

Severity: There was actual risk of harm to the residents, related to staff not having completed required education.

Scope: The scope was a pattern as it involved many of the agency staff.

Compliance History: The licensee continues to be in non-compliance with a VPC issued in March 2022.

(194)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 10, 2022(A2)

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: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s.33(1)

Specifically the licensee must ensure that:

- Residents of the home are bathed, at a minimum, twice a week by the method of their choice.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of this or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint from Family Council was received related to the provision of bed baths during the outbreak.

Inspector #194 was informed by Acting DOC and Acting ADOC, that the direction for discontinuation of bathing in the tub room at the home during the outbreak came from Public Health.

A Public Health Nurse confirmed that the Public Health Unit had not provided the Home with any direction to discontinue bathing of residents in the tub room, during the outbreak.

IPAC representative from a Third Party, confirmed that there was no communication related to the discontinuation of baths at the home during the recent outbreak.

IPAC representative from a Third Party, confirmed that they had been involved with home at the onset of the outbreak. IPAC lead confirmed that they completed an IPAC Audit, with some concerns reported, documented, and provided to the home regarding IPAC practices at the home. IPAC Lead confirmed that at no time was there any discussion with them related to the bathing practices at the home

A resident confirmed that during the outbreak they were provided with bed baths, and staff were using shower caps. Resident stated that they would have preferred a bath and to have their hair washed in the tub. The plan of care for resident indicated that they preferred a bath. Review of the bathing records confirmed that the resident received bed baths during the reviewed period.

The SDM for a resident confirmed that the resident received bed baths, during the recent outbreak. SDM stated that tub baths would have been preferred and that the resident's hair could have been washed during the bathing process. The plan of care for resident indicated that they preferred a bath. Review of the bathing records confirmed that the resident received bed baths, for the reviewed period.

Another resident confirmed receiving bed baths during the recent outbreak but would have preferred their tub bath. The plan of care for resident indicated that they preferred a bath.

Failing to ensure that residents are bathed, twice weekly, by the method of their choice, decreases the quality of life for the resident.

Source: Clinical health records for residents, interview with IPAC representatives from third party and residents. [s. 33. (1)]

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

Severity: There was minimal harm to the residents.

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

Scope: The scope was widespread, with all residents receiving bed baths during the outbreak.

Compliance History: There was a previous VPC issued in December 2019.(194) (194)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jun 15, 2022(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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

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

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

Issued on this 14th day of June, 2022 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by CHANTAL LAFRENIERE (194) - (A2

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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