Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 04, 2016;	2015_381592_0028 (A1)	O-002869-15	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH P.O. BOX 429 LANCASTER ON K0C 1N0

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

MELANIE SARRAZIN (592) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested a 3-month extension related to the compliance order #001, on March 2, 2016. The compliance order #001 due date of March 31st, 2016 has been changed. The new compliance date is June 30th, 2016.

Issued on this 4 day of March 2016 (A1)

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

Original report signed by the inspector.

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

MELANIE SARRAZIN (592) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 16, 17, 18, 19, 20, 23, 24, 25 and 26, 2015

During the course of the inspection, the inspector(s) also conducted 4 Critical Incidents:

Log# O-002456-15, Log# O-002911-15, Log# O-002146-15 and Log# O-002258-15

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Chair of Residents' Council, Member of Family Council, Personal Support

Workers (PSW), Behaviroul Support Worker (BSO), Housekeeping Aides, Rehabilitation/Restorative Care, Registered Nurses (RN), Registered Practical Nurses (RPN), maintenance worker, Director of care (DOC)/ Resident Assessment (RAI) Coordinator and the Administrator.

In addition, the inspectors reviewed resident health care records including plans of care, assessment and monitoring data, along with nursing staffing patterns, and programs such as the home's fall, medication, prevention of abuse, complaint and skin programs. Inspectors also observed meal service, resident care, staff/resident interaction and resident areas for cleanliness and repair."

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

On November 18, 2015, lingering offensive odors were identified by Inspector #550 in two resident's washrooms.

On November 20, 2015, a lingering offensive odor was identified in one of the same resident's washroom and in an additional resident washroom by Inspector #549.

On November 23, 24 and 25, 2015, lingering offensive odors were noted in all of the identified resident washrooms at different times of the day by Inspector #549.

During an interview with the housekeeping staff #107 it was indicated to Inspector #549 that the identified resident washrooms are cleaned more often due to odors and a product called "Urine Off" is used in these washrooms however, the "Urine Off" only works for a few hours then the offensive odors returns. Housekeeping staff #107 indicated that the floors in the identified resident washrooms needed to be replaced as the offensive odors has penetrated the flooring.

During an interview with Maintenance worker #102, he identified the home’s Administrator as the person responsible for the Environmental and Housekeeping departments.

During an interview on November 23, 2015, the Administrator indicated that she is aware of the offensive lingering odors in the identified resident washrooms and that the odors has penetrated the flooring. The Administrator provided Inspector #549 with a memo which is posted in the housekeeping room. The poster indicated that if any washrooms has odors after it has been cleaned or reported by other staff or families do the following: Use the product "Urine Off" as per manufactures directions in the room with undesirable odor. Indicate what washrooms you had to use the product in the Deep Cleaning list. Please let your supervisor know if the product is not successful in the area you used it. The memo was not dated or signed. The Administrator confirmed with Inspector #549 that the "Urine Off" does not manage the lingering offensive odors in the identified resident washrooms.

During an interview on November 25, 2015, the Administrator confirmed with Inspector #549 that the home does not have procedures for managing lingering offensive odors other than the memo posted in the housekeeping room which is specific to washrooms. The Administrator indicated to Inspector #549 that she would check with her head office to see if there is a corporate policy or procedure related to managing lingering odors.

November 26, 2015 the Administrator indicated to Inspector #549 that their corporate office does not have a policy for managing lingering offensive odors and it is up to each home to develop and implement their own procedures for managing offensive lingering odors.

As such the home did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

The Administrator also acknowledged that the home has a history of non-compliance related to lingering odors. A voluntary Plan of Correction was issued during the Resident Quality Inspection, November 26, 2014, Inspection # 2014_225126_0030. [s. 87. (2) (d)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A resident washroom was observed on November 17, 2015, to have pieces of tiles missing around the base of the front of the toilet approximately one inch wide exposing the concrete floor. The exposed concrete was stained brown.

A second resident washroom was observed on November 18 and 20, 2015, to have two arm rest permanently attached to the toilet. The arms of the armrests are grey in colour and made of a type of material that appears slightly padded. The right side of the arm rest was torn exposing porous material. There was grey tape around the torn armrest that was also torn and frayed which was darkened with what appears to be dirt.

A third resident washroom was observed on November 17 and 20, 2015, to have a piece of laminate missing around the sink counter top approximately five inches long exposing the porous material underneath. The sink in the washroom was stained brown around the drain.

A fourth resident washroom was observed on November 18 and 20, 2015, to have the vinyl baseboard beside the toilet ripped for approximately twelve inches with dark debris in the rip. The vinyl flooring around the toilet was stained dark brown. The light coloured vinyl flooring was pitted with dark matter which the inspector was not able to scrape off.

A fifth resident washroom was observed on November 17 and 20, 2015, to have a hole in the wall where the drainage pipe enters from the sink approximately four inches in diameter on both side of the drain pipe. The tile floor was stained brown around the base of the toilet.

A sixth resident washroom was observed on November 19 and 20, 2015, to have missing tile around the front base of the toilet exposing the concrete floor for approximately three inches. The concrete floor was stained yellow and brown. The white toilet seat had a large chip on the left hinge where the seat connects to the toilet; the chipped area was brown in colour. The black vinyl baseboard beside the toilet was pulled away from the wall leaving a gap of approximately two inches between the baseboard and the wall for approximately three feet exposing the plaster. The light fixture on the wall over the sink is approximately three feet long. The light

fixture did not have a cover on it exposing two florescent bulbs.

A seventh resident washroom was observed on November 17 and 20, 2015, to have missing tiles around the base of the toilet exposing an area of approximately three inches of the concrete floor. The exposed concrete floor was stained yellow and brown.

A eighth resident washroom was observed on November 18 and 20, 2015 to have a brown stain on the flooring around the base of the toilet spreading out about three inches.

At the entrance to a resident room, there was two areas where the floor tiles are chipped. Each area is approximately four inches long, 3/4 of an inch wide and 1/4 inch deep exposing the concrete floor.

At the end of the resident hallway down from the Activity Room at the exit door there were six broken tiles with three areas where the concrete was exposed. The exposed areas were as follows:
1. Approximately five inches long1/2 inch wide and one inch deep.
2. Approximately six inches long 1/2 inch wide and one inch deep.
3. Approximately one foot long,1/2 inch wide and one inch deep.
All of the noted areas had some dirt, leaves, pebbles and stones in them.

At the entrance to another resident room, there is a piece of missing floor tile approximately one inch by one inch.

The large window at the exit door by the laundry room had a crack running from the bottom of the window up for approximately three feet.

The entrance at both of the laundry room doors have missing tiles running the length of the door entrance approximately 1/2 inch wide exposing the concrete floor.

Three resident's rooms where observed to have large holes in the mesh at the top of the privacy curtains.

On November 20, 2015, during an interview maintenance worker #102 indicated that the home has a process for requesting maintenance repairs. Staff #102 indicated that all staff is required to put a repair request in the Maintenance Repair binder which is kept at the nursing station. Staff #102 further indicated that he checks the

Maintenance Repair binder daily. Inspector #549 reviewed the Maintenance Repair requests for the period of January 2015 to November 25, 2015 and was unable to locate any request for the above mentioned required repairs.

The maintenance worker #102 during the same interview on November 20, 2015, indicated that he is aware of the repairs that are required in the resident washrooms and that the Administrator is responsible for completing the repairs. He further indicated to Inspector #549 that he does not know what the plan is for the repairs to the home including the resident washrooms, the flooring, the privacy curtains or the cracked window.

During an interview with the Administrator on November 23, 2015, Inspector #549 was provided with a document titled "Operations Plan Submission, Renovation of Resident Washrooms" submitted to the home's head office on November 19, 2015. The submission is a request to renovation some of the resident washroom's mentioned above. The submission does not indicate a start or completion date for the renovations. The Administrator provided Inspector #549 with an e-mail dated November 26, 2015 from the Regional Operations Director indicating that the identified washroom renovations have been approved by the corporate office and the contractor has confirmed a start date of December 7, 2015.

The Regional Operations Director also indicated that the start date is contingent on Ministry of Health and Long Term Care approval which has been submitted.

The "Operations Plan Submission, Renovation of Resident Washrooms" submission by the Administrator does not include identified required repairs to the flooring, the cracked window or the privacy curtains.

The Administrator also acknowledged that the home has a history of non-compliance related to safe condition and good state of repair of furnishings and equipments. A voluntary Plan of Correction was issued during the Resident Quality Inspection, November 26, 2014, Inspection # 2014_225126_0030. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Chateau Gardens is a 60 bed Long-Term Care Home in Lancaster. Inspector #148 reviewed the registered nursing staffing schedule from July 15, 2015 to November 7, 2015 and spoke with the home's DOC. It was demonstrated that there was no Registered Nurse on duty and present in the home for the following 13 shifts:
July 15, 6pm-10pm;
August 4, 6pm-6am;
September 5, 6am to 6pm;
September 22, 6pm-4am;
September 28, 6pm-6am;
September 29, 6pm-10pm;
October 5, 6pm-6am;
October 6, 6pm to 10 pm;
October 10, 6pm-10pm;
October 11, 6pm -10pm;
October 19, 6pm-6am;
October 20, 6pm-6am;
November 6, 6pm-6am.

On November 23, 2015, the home's DOC confirmed to Inspector #148 that there is a

staffing plan in place that includes a back-up plan that addresses situations when the registered nursing staff are not able to come to work. The DOC described that when a registered nurse is not able to come to work that the home will attempt to contact all available RNs, on staff, to fill the vacant shift. If the home is unsuccessful the home will then contact RPNs, on staff, to replace the vacant RN shift with either the DOC or an RN on call. Each of the shifts identified above, were covered by an RPN in the home, the DOC indicating that there would have been herself or an RN available by phone. Upon further discussion with the DOC, none of the shifts identified above met the exceptions described under O.Reg 79/10. S. 45 (1), as they related to a home with fewer than 65 beds.

Interviews with both the home's DOC and Administrator indicated that the home has struggled with RN staffing over the course of 2015. Circumstances such as the loss of two full time RNs, a leave of absence and contract changes related to overtime have made filling vacant RN shifts challenging. As indicated by the home's Administrator, the home has made attempts to recruit RNs through a minimum of three job postings over the last year, in January, September and October 2015.

The scope of the issue of not having a Registered Nurse on site was a pattern with the severity of the issue being a potential for actual harm to residents.

The licensee has failed to ensure that there is a Registered Nurse on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 17. (1) (g) in that every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

During observations of residents rooms and common areas done on November 16th, 17th and 18th, 2015, all inspectors noticed that call bells sound in the resident care unit hallways were faint.
The speakers for the nursing call bell system are located at the nursing stations which is located at the entrance of each hallway.

On November 17, 2015, Inspector #550 activated the call bell in a specified resident room on North hallway and was unable to hear call bell, as there were 2 staff present nearby talking to one another. Once the staff stopped speaking, inspector was able to hear the call bell. Inspector walked to the end of the hallway and the call bell sound was very faint.

On November 18, 2015, Inspector #550 activated the call bell in a specified resident room on East hallway and was unable to hear the call bell in the hallway as their was a fan "on" at the end of the hallway.

On November 18, 2015, Inspector #592 activated the call bell in a specified resident room on North hallway and was unable to hear call bell in the room when the door was closed. The DOC who was present in the room at that time, indicated that she was unable to hear the call bell. She further indicated upon going to the nursing station that the volume of the communication system could not be increased as it was at the maximum sound level.

On November 18, 2015, Inspector #592 activated the call bell in three specified resident's rooms located at the end of the East hallway and was unable to hear the call bell when room doors were closed.
Inspector #592 also activated the call bell in two specified resident's rooms located at the end of the North hallway and was unable to hear the call bell when room doors were closed.

On November 18, 2015, in an interview, PSW #101 told inspector #592 that call bells were not audible when the staff were in a resident's room and the doors were closed. She further told inspector #592 that the call bell sound was getting faint from the middle of East and North wing hallways to the end of both hallways. In addition, she told inspector #592 that it was brought forward to the management but no changes have been done in regards to the call bell system.

On November 18, 2015, in an interview, maintenance worker #102, told inspector #592 that it has been several years that the home is planning to change their calling bells communication system. He further indicated that the staff were often relying on the dome light outside of the residents rooms rather than the sound to respond to resident's needs, especially for East and North middle hallways to the end.

On November 18, 2015, the administrator indicated to inspector #592, that the home resident-staff communication and response system was old and that the home was expecting to have a new calling bell system with pagers in place by the end of the year. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is properly calibrated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident bedrooms occupied by more than one resident have sufficient privacy curtains to provide privacy.

Resident #028 is cognitively impaired and requires a mechanical lift for all transfers. The resident resides in a four bed ward accommodation with a ceiling lift above the bed.

The privacy curtain between the wall and the lift track does not meet the privacy curtain on the other side of the ceiling track due to a screw in the curtain track preventing the privacy curtain from being fully drawn, leaving a gap of approximately four inches on the left side of the resident's bed. When the privacy curtain on the other side of the ceiling track above the resident's bed is drawn there is a gap of approximately three feet where the privacy curtains do not meet.

On November 20, 2015 the DOC observed and confirmed with Inspector #549 that when the privacy curtains around Resident #028's bed are fully drawn they do not provide completed privacy for the resident. [s. 13.]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.

The home's Administrator identified policy #LTC-CA-ALL-100-05-02, titled Resident Abuse- Abuse Prevention Program – Whistle-Blowing Protection, as the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the policy indicates elements of reporting to the Ministry of Health and Long Term Care (i.e Director). However, explanations related to the reporting of abuse and neglect of residents, do not indicate immediate reporting. The explanations provided does not clearly indicate that a person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall be reported.

In addition, the policy does not include the duty to report as it relates to improper/incompetent care, unlawful conduct and the misuse/misappropriation of resident's money or funding.

The home's policy to promote zero tolerance of abuse and neglect of residents, does not provide for a clear explanation of the duty under section 24 of the Act.

In accordance with LTCHA 2007, c.8, s.20(2)(h) and Regulation 79/10, s.97(1)(b), the home's policy shall deal with any additional matters as may be provided for in the regulations including the notification of the resident's substitute decision maker (SDM). The home's policy describes the immediate notification of the SDM in relation to alleged incidents of abuse or neglect whereby the resident sustained a physical injury, pain or distress, but does not include the requirement to notify the SDM of all other alleged incidents of abuse or neglect within 12 hours. [s. 20. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (Log #O-002911-15)

1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

On a specific date in October 2015, RPN #103 send an email to the Director of care and the Administrator about an incident which occurred. The email indicates that RPN #103 and her co-worker heard a scream coming from the East wing. The email further indicates that upon responding to the scream, both RPN noticed that Resident #020 appeared to be trying to get loose from PSW #118. The email further indicates that it looked like PSW #118 let go of Resident #020 as soon as both RPN's were coming down the hall. The email further indicates that Resident #020 was in one of his/her

agitated moods but complained that his/her arm hurt. The email further indicates that when both RPNs rolled Resident's #020 sleeve up and looked, there was a very new reddened mark just above his/her elbow and RPN #103 felt that she needed to report this incident as she was afraid that PSW #118 may have been a little too rough with Resident #020.

On November 25, 2015, in an interview, RPN #103 told inspector #592 that she was the person in charge on a specific date in October 2015. She told Inspector #592 that she heard a yell in the corridor and both her and her co-worker went down the east wing corridor. She further told Inspector #592 that she have observed one of the residents who was residing in the room, in the door way with his/her wheelchair. Upon approach, she observed PSW #118 reaching across, grabbing and pulling Resident's #020 hands in a rough manner which she thought was inappropriate in the attempt to remove resident's #020 hands from the wheelchair. She further indicated that resident #020 followed her to the nurses desk and complained of pain and had fresh marks on his/her arm. She further told inspector #592 that she did not report immediately to the Director because she did not feel it was physical abuse and that resident #020 was not in danger. RPN #103 further told inspector #592 that the home does have a list available for staff members with the type of incidents and when to report to the ministry, including the after hours numbers. RPN #103 further indicated that she did not feel that this matter needed to be reported immediately to the director because she did not feel that it was physical abuse. RPN #103 further told inspector #592 that she decided in this case, to send an email to the Administrator and the DOC to keep them aware of the incident.

As per the home's Critical Incident Report #2680-000012-15, a critical incident report was submitted to the Director two days after the incident which was not immediately.

On November 25, 2015, in an interview, the Administrator told Inspector #592 that an email was sent by RPN #103 who was in charge a specific date in October 2015, to the attention of her and the DOC. She told Inspector #592 that she did not look at her email has she was off duty. She further added that the DOC was the first person to receive the email on the Tuesday morning, once she arrived at the home site after coming back from the long week-end. The Administrator indicated that a review of the incident/email was done with her, the DOC and their director on that same day. She told inspector #592 that the email description was fitting the definition of abuse in the legislation which should of been reported immediately, therefore they decided to send a critical incident on that day. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan be evaluated and updated at least annually in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices.

Chateau Gardens is a 60 bed Long-Term Care Home in Lancaster. Inspector #148 reviewed the registered nursing staffing schedule from July 15, 2015 to November 7, 2015 and it was demonstrated that there was no Registered Nurse on duty and present in the home for 13 shifts. A written notification has been indicated in this report for section 8(2) under the LTCHA, 2007.

Inspector #148 requested the last evaluation of the staffing plan from the home's DOC. The most recent nursing and personal care staffing evaluation was completed March 2014. The written evaluation indicates that three shifts were identified without an RN in the home. Upon discussion with the DOC, it was reported that since this evaluation there have been changes in the ability of the home to ensure RN coverage at all times. Circumstances such as the loss of two full time RNs, a leave of absence and contract changes related to overtime have made filling vacant RN shifts challenging.

The licensee has not evaluated and updated the staffing plan, specifically as it relates to the staffing of Registered Nurses, since March 2014. [s. 31. (3)]

Issued on this 4 day of March 2016 (A1)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELANIE SARRAZIN (592) - (A1)

Inspection No. / No de l'inspection : 2015_381592_0028 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002869-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 04, 2016;(A1)

Licensee / Titulaire de permis :
Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD :
CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Shoma Maraj

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to address:

1. Incidents of persisting lingering odors, specifically in identified rooms.
2. Develop a monitoring process to ensure that the procedures implemented to address the incidents of lingering offensive odors are effective.
3. When procedures are not effective, to have a process to reassess and look at alternative procedures to address these lingering odors.

This plan must be submitted in with attention to Rena Bowen, LTCH Inspector at
347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4, by fax at 1-613-569-9670 or email OttawaSAO.MOH@ontario.ca, on or before December 23, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

On November 18, 2015, lingering offensive odors were identified by Inspector #550 in two resident's washrooms.

On November 20, 2015, a lingering offensive odor was identified in one of the same resident's washroom and in an additional resident washroom by Inspector #549.

On November 23, 24 and 25, 2015, lingering offensive odors were noted in all of the identified resident washrooms at different times of the day by Inspector #549.

During an interview with the housekeeping staff #107 it was indicated to Inspector #549 that the identified resident washrooms are cleaned more often due to odors and a product called "Urine Off" is used in these washrooms however, the "Urine Off" only works for a few hours then the offensive odors returns. Housekeeping staff #107 indicated that the floors in the identified resident washrooms needed to be replaced as the offensive odors has penetrated the flooring.

During an interview with Maintenance worker #102, he identified the home's Administrator as the person responsible for the Environmental and Housekeeping

departments.

During an interview on November 23, 2015, the Administrator indicated that she is aware of the offensive lingering odors in the identified resident washrooms and that the odors has penetrated the flooring. The Administrator provided Inspector #549 with a memo which is posted in the housekeeping room. The poster indicated that if any washrooms has odors after it has been cleaned or reported by other staff or families do the following: Use the product "Urine Off" as per manufactures directions in the room with undesirable odor. Indicate what washrooms you had to use the product in the Deep Cleaning list. Please let your supervisor know if the product is not successful in the area you used it. The memo was not dated or signed. The Administrator confirmed with Inspector #549 that the "Urine Off" does not manage the lingering offensive odors in the identified resident washrooms.

During an interview on November 25, 2015, the Administrator confirmed with Inspector #549 that the home does not have procedures for managing lingering offensive odors other than the memo posted in the housekeeping room which is specific to washrooms. The Administrator indicated to Inspector #549 that she would check with her head office to see if there is a corporate policy or procedure related to managing lingering odors.

November 26, 2015 the Administrator indicated to Inspector #549 that their corporate office does not have a policy for managing lingering offensive odors and it is up to each home to develop and implement their own procedures for managing offensive lingering odors.

As such the home did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

The Administrator also acknowledged that the home has a history of non-compliance related to lingering odors. A voluntary Plan of Correction was issued during the Resident Quality Inspection, November 26, 2014, Inspection # 2014_225126_0030. [s. 87. (2) (d)] (549)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Jun 30, 2016(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan, to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically:

1. The planned renovations for identified resident washrooms are to have a clear start and completion date.
2. The cracked window at the exit door by the laundry room.
3. The identified areas of flooring where there are broken tiles and exposed concrete.
4. The identified resident privacy curtains.
5. Procedures for when repairs are identified, that actions are taken to maintain the home, furnishings and equipment in a safe condition and in good state of repair.

This plan must be submitted in with attention to Rena Bowen, LTCH Inspector at
347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4, by fax at 1-613-569-9670 or email OttawaSAO.MOH@ontario.ca, on or before December 23, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A resident washroom was observed on November 17, 2015, to have pieces of tiles missing around the base of the front of the toilet approximately one inch wide exposing the concrete floor. The exposed concrete was stained brown.

A second resident washroom was observed on November 18 and 20, 2015, to have two arm rest permanently attached to the toilet. The arms of the armrests are grey in colour and made of a type of material that appears slightly padded. The right side of the arm rest was torn exposing porous material. There was grey tape around the torn armrest that was also torn and frayed which was darkened with what appears to be dirt.

A third resident washroom was observed on November 17 and 20, 2015, to have a piece of laminate missing around the sink counter top approximately five inches long

exposing the porous material underneath. The sink in the washroom was stained brown around the drain.

A fourth resident washroom was observed on November 18 and 20, 2015, to have the vinyl baseboard beside the toilet ripped for approximately twelve inches with dark debris in the rip. The vinyl flooring around the toilet was stained dark brown. The light coloured vinyl flooring was pitted with dark matter which the inspector was not able to scrape off.

A fifth resident washroom was observed on November 17 and 20, 2015, to have a hole in the wall where the drainage pipe enters from the sink approximately four inches in diameter on both side of the drain pipe. The tile floor was stained brown around the base of the toilet.

A sixth resident washroom was observed on November 19 and 20, 2015, to have missing tile around the front base of the toilet exposing the concrete floor for approximately three inches. The concrete floor was stained yellow and brown. The white toilet seat had a large chip on the left hinge where the seat connects to the toilet; the chipped area was brown in colour. The black vinyl baseboard beside the toilet was pulled away from the wall leaving a gap of approximately two inches between the baseboard and the wall for approximately three feet exposing the plaster. The light fixture on the wall over the sink is approximately three feet long. The light fixture did not have a cover on it exposing two florescent bulbs.

A seventh resident washroom was observed on November 17 and 20, 2015, to have missing tiles around the base of the toilet exposing an area of approximately three inches of the concrete floor. The exposed concrete floor was stained yellow and brown.

A eighth resident washroom was observed on November 18 and 20, 2015 to have a brown stain on the flooring around the base of the toilet spreading out about three inches.

At the entrance to a resident room, there was two areas where the floor tiles are chipped. Each area is approximately four inches long, 3/4 of an inch wide and 1/4 inch deep exposing the concrete floor.

At the end of the resident hallway down from the Activity Room at the exit door there

were six broken tiles with three areas where the concrete was exposed. The exposed areas were as follows:
1. Approximately five inches long1/2 inch wide and one inch deep.
2. Approximately six inches long 1/2 inch wide and one inch deep.
3. Approximately one foot long,1/2 inch wide and one inch deep.
All of the noted areas had some dirt, leaves, pebbles and stones in them.

At the entrance to another resident room, there is a piece of missing floor tile approximately one inch by one inch.

The large window at the exit door by the laundry room had a crack running from the bottom of the window up for approximately three feet.

The entrance at both of the laundry room doors have missing tiles running the length of the door entrance approximately 1/2 inch wide exposing the concrete floor.

Three resident's rooms where observed to have large holes in the mesh at the top of the privacy curtains.

On November 20, 2015, during an interview maintenance worker #102 indicated that the home has a process for requesting maintenance repairs. Staff #102 indicated that all staff is required to put a repair request in the Maintenance Repair binder which is kept at the nursing station. Staff #102 further indicated that he checks the Maintenance Repair binder daily. Inspector #549 reviewed the Maintenance Repair requests for the period of January 2015 to November 25, 2015 and was unable to locate any request for the above mentioned required repairs.

The maintenance worker #102 during the same interview on November 20, 2015, indicated that he is aware of the repairs that are required in the resident washrooms and that the Administrator is responsible for completing the repairs. He further indicated to Inspector #549 that he does not know what the plan is for the repairs to the home including the resident washrooms, the flooring, the privacy curtains or the cracked window.

During an interview with the Administrator on November 23, 2015, Inspector #549 was provided with a document titled "Operations Plan Submission, Renovation of Resident Washrooms" submitted to the home's head office on November 19, 2015. The submission is a request to renovation some of the resident washroom's

mentioned above. The submission does not indicate a start or completion date for the renovations. The Administrator provided Inspector #549 with an e-mail dated November 26, 2015 from the Regional Operations Director indicating that the identified washroom renovations have been approved by the corporate office and the contractor has confirmed a start date of December 7, 2015.

The Regional Operations Director also indicated that the start date is contingent on Ministry of Health and Long Term Care approval which has been submitted.

The "Operations Plan Submission, Renovation of Resident Washrooms" submission by the Administrator does not include identified required repairs to the flooring, the cracked window or the privacy curtains.

The Administrator also acknowledged that the home has a history of non-compliance related to safe condition and good state of repair of furnishings and equipments. A voluntary Plan of Correction was issued during the Resident Quality Inspection, November 26, 2014, Inspection # 2014_225126_0030. [s. 15. (2) (c)] (549)

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

Mar 31, 2016

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan with strategies for achieving compliance to meet the requirement that at least one registered nurse who is both an employee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. The plan shall also include all recruiting and retention strategies.

This plan must be submitted in with attention to Amanda Nixon, LTCH Inspector at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4, by fax at 1-613-569-9670 or email OttawaSAO.MOH@ontario.ca, on or before December 23, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Chateau Gardens is a 60 bed Long-Term Care Home in Lancaster. Inspector #148 reviewed the registered nursing staffing schedule from July 15, 2015 to November 7, 2015 and spoke with the home's DOC. It was demonstrated that there was no Registered Nurse on duty and present in the home for the following 13 shifts:
July 15, 6pm-10pm;
August 4, 6pm-6am;
September 5, 6am to 6pm;
September 22, 6pm-4am;
September 28, 6pm-6am;
September 29, 6pm-10pm;
October 5, 6pm-6am;
October 6, 6pm to 10 pm;
October 10, 6pm-10pm;

October 11, 6pm -10pm;
October 19, 6pm-6am;
October 20, 6pm-6am;
November 6, 6pm-6am.

On November 23, 2015, the home's DOC confirmed to Inspector #148 that there is a staffing plan in place that includes a back-up plan that addresses situations when the registered nursing staff are not able to come to work. The DOC described that when a registered nurse is not able to come to work that the home will attempt to contact all available RNs, on staff, to fill the vacant shift. If the home is unsuccessful the home will then contact RPNs, on staff, to replace the vacant RN shift with either the DOC or an RN on call. Each of the shifts identified above, were covered by an RPN in the home, the DOC indicating that there would have been herself or an RN available by phone. Upon further discussion with the DOC, none of the shifts identified above met the exceptions described under O.Reg 79/10. S. 45 (1), as they related to a home with fewer than 65 beds.

Interviews with both the home's DOC and Administrator indicated that the home has struggled with RN staffing over the course of 2015. Circumstances such as the loss of two full time RNs, a leave of absence and contract changes related to overtime have made filling vacant RN shifts challenging. As indicated by the home's Administrator, the home has made attempts to recruit RNs through a minimum of three job postings over the last year, in January, September and October 2015.

The scope of the issue of not having a Registered Nurse on duty was a pattern with the severity of this issue being a potential for actual harm to residents.

The licensee has failed to ensure that there is a Registered Nurse on duty and present in the home at all times.
(148)

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

Mar 31, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4 day of March 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELANIE SARRAZIN - (A1)

Service Area Office /
Bureau régional de services : Ottawa