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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 14, 2016;	2016_346133_0031 (A1)	023484-15	Follow up

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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The compliance date for compliance order #001 has been amended, as requested by the licensee on November 10th, 2016. The original compliance date was November 14th, 2016. The new compliance date is December 5th, 2016. No other changes have been made to the Inspection Report.

Issued on this 14 day of November 2016 (A1)

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

Original report signed by the inspector.

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 29, 30, 31 - 2016 (on site)

This Follow Up Inspection was related to a compliance order regarding maintenance of the home.

During the course of the inspection, the inspector(s) spoke with the Maintenance Supervisor, the Director of Care, the Office Manager, housekeeping staff, registered and non registered nursing staff, an Extendicare Assist Long Term Care Consultant and the Extendicare Assist Regional Director with responsibility for the home.

The inspector observed resident bedrooms and common areas throughout the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Safe and Secure Home

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

- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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 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 comply with LTCHA, 2007, c. 8, s. 15 in that 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.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Voluntary Plan of Correction was issued, and the licensee was served with an immediate Compliance Order (CO). As a result of Other inspection #2015_346133_0005, conducted in February 2015, the licensee was served with a Compliance Order (CO #001), with a compliance date of July 20, 2015. As a result of Follow Up inspection #2015_346133_0029, conducted in August 2015, the licensee was served with a Compliance Order (CO #001), with a compliance date of August 22, 2016. Written notifications were issued, as additional evidence for the Compliance Order (CO) due for August 22, 2016, as a result of Follow Up inspection #2015_346133_0040 (WN # 1) in October 2015, Resident Quality Inspection #2015_286547_0025 (WN # 15) in December 2015, and Follow Up inspection #2016_346133_0027 (WN# 2) in July 2016.

The home's former Administrator, who was also the designated lead for the maintenance program, left the home in early August 2016. The home was being covered by an acting Administrator, available by phone and email, at the time of the inspection. The home's maintenance worker, #S103, began working at the home in early May 2016. He was confirmed as the permanent Maintenance Supervisor on August 30th, 2016, during the inspection. In this role, he is the designated lead for the maintenance services program as per O. Reg. 79/10, s. 92. He is referred to as the Maintenance Supervisor (MS) throughout this report.

On August 31st, 2016, related to the requirement within the CO to implement a routine auditing program to ensure sustained adherence to the home's written procedures related to maintenance of the home, the MS advised that he was not aware of such a program. Although aware of some of the corrective actions taken in response to the CO, the MS did not have the background to review and discuss the CO with the Inspector. A progress report submitted by the former Administrator on December 10th, 2015, in response to the CO, stated that "ongoing supervision is in place and a routine auditing program is in place via the designated lead". The Inspector was unable to gather any further information about this over the course

of the inspection.

The MS explained that he had recently been made aware, by the Extendicare Assist Regional Director with responsibility for the home, #S106, that there were policy manuals in the home for him to review, which outlined the routines that should be followed with regards to the maintenance program. He explained he had looked through some of them, over the course of the inspection, and was aware of the need to implement a preventative maintenance program. He explained that he was not following any of the manuals, and that he was only finding time to respond to immediate day to day maintenance needs, because there was so much work to do. As well, he was not finding the time to write anything down, yet he knew this was necessary in order to document actions taken. The MS indicated that he was aware of a few main ongoing problems at the home, such as floors, windows, doors (see WN # 3 in this inspection report) and the roof. Related to the roof, there had been flooding at the home, in some bedrooms, in early August 2016. Final corrective actions were being taken by the roofing company over the course of the inspection.

On August 30th, 2016, the Extendicare Assist Regional Director with responsibility for the home, #S106, did inform the Inspector, via email communication, that there was an orientation plan for the new MS.

The following observations were made over the course of the Follow Up inspection, August 29th – 31st, 2016. Ongoing non-compliance was observed, specifically with regards to windows and floors.

Resident bedroom windows:

Bedroom #116 – Resident #003's window was in poor repair. There was a very heavy accumulation of condensation between the panes of the openable window and the upper window seal was hanging loosely, in pieces, between the panes. There was accumulation of rusted pieces of the seal between the panes, along the base, and rust along the lower area of the panes.

Bedroom #110 – The window was in poor repair. There was heavy accumulation of condensation between the panes of the openable window, there were streaks of rust running down the panes, and the inner seal around the panes was cracked and rusty.

Bedroom #131 – Within the bed space on the left side of the bedroom, the window was in poor repair. There was accumulation of condensation between the panes of the openable window, the inner seal had crumbled apart, with pieces of the seal stuck to the upper area of the panes and accumulation of the crumbled seal along the base.

Within the bed space on the right side of the bedroom, the window was in poor repair. There was accumulation of condensation between the panes of the openable window. There were streaks of rust running down the panes. There was accumulation of rust and parts of the crumbled seal along the base of the panes.

Bedroom #141 – The window was in poor repair. There was accumulation of condensation between the panes of the openable window. The inner seal had crumbled and pieces of it were stuck to the panes. There was accumulation of rust and parts of the crumbled seal along the base of the panes.

Note: Resident #003's window, in bedroom #116, was specifically referenced in the Compliance Order served as a result of Follow Up inspection #2015_346133_0029, conducted in August 2015. The licensee was ordered to implement a repair/replacement plan for all resident bedroom windows that were in poor repair, for August 22nd, 2016. On July 12th, 2016, a progress report submitted by the former Administrator stated that 42 small windows and 10 large windows had been replaced. The MS was not able to speak to how the former Administrator decided which windows needed to be replaced. The MS stated that there were approximately 10 more windows that needed to be replaced.

Resident washroom floors:

Bedroom #130 – In the washroom, the vinyl sheet flooring had shrunk and there was a loss of adhesion between the flooring and the concrete slab. The affected area was behind the toilet and along the wall next to the toilet, between the toilet and the wall. The edge of the flooring had pulled away from the baseboards, creating a gap of approximately half an inch. Accumulated dirt and debris was observed within the gap. The loose flooring was raised throughout the affected area.

Bedroom #106 – In the washroom, the vinyl sheet flooring had shrunk and there was a loss of adhesion between the flooring and the concrete slab. The affected area was the full length of the wall to the side of the sink, under the sink and

counter, and along the wall to the left of the doorway. The edge of the loose flooring was raised, along the wall to the left of the doorway. The gap between the strip of white wood at the base of baseboard and the edge of the flooring ranged from half an inch to three quarters of an inch. In the past, in an effort to manage this ongoing issue, the former maintenance supervisor had installed a strip of white wood along the base of the vinyl baseboard, around the perimeter of the washroom. This was done in order to close the gap and keep the edges down. The flooring had since regressed.

Bedroom #121/#123 – In the shared washroom, under, in front of and beside the sink, the vinyl sheet flooring was not adhered to the concrete slab beneath. The loose flooring was raised throughout the affected area and there was a small gap between the flooring and the baseboard under the sink and to the side of the sink.

Note: The floor in washroom #130 was specifically referenced in the Compliance Order served as a result of Follow up inspection #2015_346133_0029, conducted in August 2015 and this overall issue was first described in the Compliance Order served as a result of Other inspection 2015_346133_0005. In the past, the Inspector has been informed that this ongoing issue is a result of excess moisture within the concrete slab beneath the flooring, as there is no sub floor.

West hallway floors:

In the short length of the west hallway, there were approximately 10 areas where the vinyl sheet flooring was not adhered to the concrete slab below. As a result, the flooring was raised and bubbled, in the centre of the hallway, presenting a potential tripping hazard for residents. All raised areas were approximately three to four inches wide and half an inch in height. The most notable area, between the tub room and shower room, in the center of the hallway, was approximately three feet in length. There were four to five shorter raised areas in the immediate proximity. There were two raised areas in the hallway, between bedrooms #125 and #131, approximately 16 inches in length each. After bedrooms #131 and #125, there was one area that was approximately two feet in length. Two subsequent areas, towards bedrooms #127 and #129, were 20 inches and 22 inches in length respectively. Between these last two raised areas, there was a cut in the flooring.

While observing this area on August 31st, 2016, Registered Practical Nurse #S108 told the Inspector that she was not aware that any resident had tripped on the

raised areas, but felt there was potential for tripping, and that overall it was a danger for the residents.

Outside of bedroom #133, closer to the opposite wall, there was one large raised curved area. The area measured two feet, from tip to tip, and was approximately four to five inches wide.

Between bedrooms #115/#145 and #119/#141, there were numerous raised areas. The areas were along the sides of the hallway as well as in the center. The areas ranged in length from four inches, up to 23 inches (between bedrooms #117 and #147). The raised areas were all approximately three inches wide and an inch and a half in height. There was a raised area between bedroom #117 and #115, towards the center of the hallway. There were several raised areas between bedrooms #117 and #119, towards the side of the hallway. There were raised areas directly in front of bedroom #143 and between bedroom #143 and #145. There was a raised area directly outside of bedroom #121, to the left side if within the bedroom. There were raised areas between bedroom #139 and #137. Along the edge of the hallway, between bedrooms #113 and #115, under the handrail, there were several smaller raised areas.

Note: The raised areas in the short length of the west hallway were specifically referenced in Written Notification (WN) #2, issued as a result of Follow Up Inspection #2016_346133_0027, in July 2016. The WN was issued as additional evidence in support of Compliance Order #001, associated to Follow Up inspection #2015_346133_0029, conducted in August 2015, which also described loose hallway flooring in the area of bedrooms #119, #145 and #115. It is noted that raised flooring directly in front of these three bedrooms was replaced. In the past, the Inspector has been informed that this ongoing issue is a result of excess moisture within the concrete slab beneath the flooring, as there is no sub floor. The Maintenance Supervisor informed that following the inspection in July 2016, he was told by the former Administrator that he could cut the raised areas in the short length of the west hallway in an effort to flatten them. He pointed out that the two raised areas closest to bedroom #127 and #129 had a cut between them, but this had not prevented the flooring from raising up on either side of the cut. He did not feel that cutting the raised areas was a suitable solution.

Lights:

Bedroom #112 – One of the two fluorescent tube lights in the ceiling mounted

fixture within the immediate entrance to the bedroom was burnt out and the other one was very dim.

Bedroom #122 – The lens for the two lights on the wall above the bedroom door, connected to the resident-staff communication and response system, was missing. This lens enhances the lights, helping staff to see where the call for assistance is coming from more effectively.

Bedroom #102 – The lower fluorescent tube light in the wall mounted light fixture above the bed was flickering and was very dim.

Bedroom #127 – The lens for the fluorescent tube light fixture on the ceiling in the washroom was missing.

Bedroom #125 – The lens for the fluorescent tube light fixture on the ceiling within the immediate entrance to the bedroom was missing.

Bedroom #133 – The upper fluorescent tube light in the wall mounted light fixture above resident #006's bed was not functional.

Hallway lights – The fluorescent tube lights in the ceiling mounted fixture outside of bedroom #151 and #109 were very dim.

Bedroom #101 - The lens for the fluorescent tube light fixture on the ceiling within the immediate entrance to the bedroom was missing.

Hallway lights – Between bedrooms 134/132 and 106/108, one of the fluorescent tube lights in the ceiling mounted fixture was burnt out and one was extremely dim.

Bedroom #135 – The metal bead chain pull cord for the light fixture above resident #008's bed was very short, with only approximately four beads remaining. The Inspector was able to turn the lights on by pulling repeatedly on the short chain, but could not turn the lights off.

Other:

Bedroom #114 – There was no screen for the window.

Bedroom #128 – The wall to the left of the washroom door was deeply gouged in several areas. The lower outer washroom door was extensively scuffed and scraped. The outer washroom door frame, on the left, paint was scraped down to the metal.

The wall divider between the two bed spaces was damaged; the lower wall surface was broken and chipped away.

Bedroom #131 – The lower wall to the right of resident #005's bedside table was in poor repair. There was a large indentation in the wall surface, above the baseboard, and the baseboard had been forced inwards. There was a gap between the floor tile and the baseboard, with accumulation of debris within the gap. Above this area, mid wall, there was one straight gouge line.

The resident's closet door was in poor repair. On the lower area of the outer closet door, the wood was broken and splintered.

Note: Resident #005's closet door was specifically referenced in the Compliance Order (CO) served as a result of Follow up inspection #2015_346133_0029, conducted in August 2015. The CO required that such damaged surfaces be remediated by November 24th, 2015. A progress report submitted by the former Administrator on December 10th, 2015 noted that the then maintenance supervisor has rejoined service (following a leave) and regular maintenance along with documentation was taking place. It stated that wall remediation was ensured via the routine maintenance program. The progress report did not specifically address resident #005's closet.

South tub room – the drain cover was missing for the floor drain, to the right of the tub.

South dining room – The wall under the windows was in poor repair. The wall under the middle window was scraped along a horizontal length with paint peeling around it. The paint under the window on the left was peeling and the wall was scuffed. The wall under the window on the right has a long length of black scuffing. The lower inner dining room door was extensively scraped and the frame on the right was scraped down to the metal. The lower wall, on the right, upon entry to the dining room, was gouged and scuffed.

Bedroom #108 – The towel bar next to the sink, in the washroom, was missing.

The right bracket for the towel bar remained in place, affixed to the wall, but the left bracket was missing.

Bedroom #110 – The bathroom exhaust fan was very loud, making a deep rattling sound.

Note: It has been previously established (inspection #2015_346133_0005, CO #001 and #2015_346133_0029, CO #001) that the exhaust is so loud in some resident bathrooms because the individual fans are old and the blades dulled. When an old fan is replaced with a new fan, the exhaust is rendered almost silent. There are times when the bathroom exhaust only comes on when the light is turned on, and other set times when the exhaust runs automatically. It has been previously established that when the exhaust comes on automatically and the bathroom door is open, and there is an old fan in place which is loud, it can be disruptive to residents as they rest. A progress report submitted by the former Administrator on December 10th, 2015 noted that three noisy exhaust fans had been replaced and that further replacement of fans would be done as required.

The home's current Maintenance Supervisor indicated that he was not aware of a replacement program for the exhaust fans

Bedroom #A - On August 30th, 2016, it was observed that the cover for the toilet tank was sitting across the toilet seat and the flushing mechanism was inoperable. Resident # 007 told the Inspector that she/had to use the toilet in the main lobby if she/he needed to have a bowel movement, and hoped her/his toilet would be fixed that day. A housekeeper, #S107, told the Inspector that she had discovered that this toilet was broken on August 29th, 2016, had reported it to the Maintenance Supervisor (MS) upon discovery, and had reminded him about it on that day (August 30th, 2016). Towards the end of the inspection day, on August 31st, 2016, the MS explained that he had found a replacement flushing mechanism for this toilet in the maintenance room, and that the toilet was now functional. Resident #007 had to use the toilet in the main lobby for three days.

West dining room: The wall under the third window (from entrance) was cracked and peeling. The area had been partially patched. The wall under the first window was cracked and indented in two areas above the baseboard and was scuffed all around the damaged area.

The widespread nature of the observed non-compliance observed, the potential

risk to residents presented by some of the non-compliance and the licensee's history of non-compliance related to maintenance requires a subsequent Compliance Order (CO) be issued. As well, as this will be the fourth CO served to the licensee pursuant to LTCHA, 2007, s. 15 (2) (c), a referral to the Director will be made. [s. 15. (2) (c)]

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 3 (1) 8. as the licensee failed to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs are fully respected and promoted.

On August 29th, 2016, at approximately 12:05 hrs, upon approach to the short length of the South hallway, the inspector heard a resident yelling out. The inspector turned the corner and observed that the tub room door was open approximately one third of the way. Within the tub room, the inspector observed that it was resident #001 yelling out. Words were not discernable. The resident was standing, within a sit to stand lift, facing out into the hallway. Personal Support Worker (PSW) #S102 was standing behind the resident, facing out into the hallway. PSW #S101 had her back to the hallway and was operating the lift, yet her position did not obscure the view of the resident. The resident's shirt had been pulled over his/her head, and his/her arms were within the sleeves. The resident's shirt had not been pulled down over his/her chest, and therefore the resident was in a state of undress from his/her waist up to his/her neck. PSW #S102 saw the inspector standing in the hallway, observing the interaction, and made no move to lower the resident's shirt or to have the door closed. The inspector observed as the resident was positioned down into his/her wheelchair. Once the resident was seated, PSW #S102 lowered the resident's shirt to cover his/her chest area.

PSW #S102 told the inspector that the tub room door had to be kept open because it was hot in the room.

Resident #001 was unable to discuss the incident with the inspector due to cognitive impairment.

The incident was reported to the Director of Care that afternoon and disciplinary actions were taken. [s. 3. (1) 8.]

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 with the requirement to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs are fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1 i. in that the licensee has failed to ensure that all doors leading to stairways and the outside of the home are kept closed and locked.

This finding is specific to the basement stairway door.

The licensee was served with a Compliance Order (CO), #001, pursuant O. Reg. 79/10, s. 9 (1) on July 12th, 2016 as a result of Follow Up inspection #2016_346133_0027. Full compliance for the CO is due on November 14, 2016.

The evidence presented below is additional information for CO #001, and will be included in the follow up inspection.

On August 30th, 2016, at approximately 13:45 hrs, the inspector and the home's new Director of Care (DOC), #S104, went into the basement and discovered that the stairway door was no longer locked. It was also discovered that the fire exit door in the chapel, and the door leading into the service corridor were no longer locked. The basement is accessible to residents via the elevator, which is not equipped to restrict resident access to the basement, because of the chapel. The stairway door leads into a corridor. At the end of the corridor, there is an unlocked and unalarmed exit door, which leads to the outside of the home, where there is a ravine and a wooded area.

Following this discovery, the inspector spoke with the home's new Maintenance Supervisor (MS), #S103, who informed that the doors had been unlocked since the week before. He explained that contractors had been into the home to consult about the installation of a door alarm system, as required by the CO referenced above. He explained that following their assessment of the wiring in the basement, he discovered that the magnetic locks for the three doors were no longer functional. The MS explained that he did not feel that these unlocked doors presented a risk to residents, as normally there is only one resident, #002, who routinely goes to the basement, to pray in the chapel. He did not feel that this resident would go anywhere other than the chapel. He acknowledged that the elevator is not equipped to restrict resident access to the basement, and that it is therefore possible that other residents could go down to the basement.

It was noted that at the time of the inspection, the staff room in the basement was under repair. There were tables set up in the foyer of the basement, for staff to use during breaks. The inspector was in the basement twice on August 30th, and both times it was observed that several staff members were in the foyer, within the immediate area of the unlocked stairway door.

The Extendicare assist Long -Term Care Nursing Consultant, #S105, was in the home on that day to orient the new DOC. The inspector, the consultant, and the DOC met to further discuss the basement doors and the potential for risk to

residents. The consultant informed that they would immediately call in a Personal Support Worker (PSW) to sit at the elevator access area on the main floor, to ensure that no resident could gain access to the basement unsupervised. By the end of the inspection day, there was a PSW in place. As well, as a further safety measure, the elevator had been put on service mode in the basement, rendering it inaccessible to the residents. The inspector was informed that the PSW would be stationed at the elevator access area on the main floor for 72 hours, to help all staff become familiar with the new process for accessing the elevator in the basement and then returning it to the basement. Residents wishing to go downstairs were to be accompanied by staff. The inspector observed this process in place on August 31st, 2016, over the remaining course of the follow up inspection. [s. 9. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2. in that the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and that those door are kept closed and locked when they are not being supervised by staff.

The licensee was served with a Compliance Order (CO), #001, pursuant O. Reg. 79/10, s. 9 (1) on July 12th, 2016 as a result of Follow Up inspection #2016_346133_0027. Full compliance for the CO is due on November 14, 2016.

The evidence presented below is additional information for CO #001, and will be included in the follow up inspection.

On August 30th, 2016, at approximately 13:45 hrs, the inspector and the home's new Director of Care (DOC), #S104, went into the basement and discovered that the fire exit door within the chapel, and the door leading into the service corridor, were no longer locked. It was also discovered that the stairway door was no longer locked. The fire exit door in the chapel leads into a hallway, which is a non-residential area. Directly across from the chapel exit door, in the hallway, there is an unlocked and unalarmed door to the outside of the home, where there is a ravine and a wooded area. The service corridor door leads into an expansive service area, which is a non-residential area. At approximately 14:15 hours, the inspector observed the following within the service corridor: the laundry room, which was not locked and not supervised; the maintenance room, which was not locked and not supervised; an unlocked door to the parking garage in which there were two unlocked and unalarmed doors to the outside; and around the corner from the main hallway, another unlocked and unalarmed door to the outside of the

home, to the garbage and recycling area in front of the parking garage.

The basement is accessible to residents via the elevator, which is not equipped to restrict resident access to the basement, because of the chapel. One of the chapel doors if left unlocked at all times, to allow for resident access.

Following this discovery, the inspector spoke with the home's new Maintenance Supervisor, #S103, who informed that the doors had been unlocked since the week before. He explained that contractors had been into the home to consult about the installation of a door alarm system. He explained that following their assessment of the wiring in the basement, he discovered that the magnetic locks for the three doors were no longer functional. The MS explained that he did not feel that these unlocked doors presented a risk to residents, as normally there is only one resident, #002, who routinely goes to the basement, to pray in the chapel. He did not feel that this resident would go anywhere other than the chapel. He acknowledged that the elevator is not equipped to restrict resident access to the basement, and that it is therefore possible that other residents could go down to the basement.

The Extendicare assist Long -Term Care Nursing Consultant, #S105, was in the home on that day to orient the new DOC. The inspector, the consultant, and the DOC met to further discuss the basement doors and the potential for risk to residents. The consultant informed that they would immediately call in a Personal Support Worker (PSW) to sit at the elevator access area on the main floor, to ensure that no resident could gain access to the basement unsupervised. By the end of the inspection day, there was a PSW in place. As well, as a further safety measure, the elevator had been put on service mode in the basement, rendering it inaccessible to the residents. The inspector was informed that the PSW would be stationed at the elevator access area on the main floor for 72 hours, to help all staff become familiar with the new process for accessing the elevator in the basement and then returning it to the basement. Residents wishing to go downstairs were to be accompanied by staff. The inspector observed this process in place on August 31st, 2016, over the remaining course of the follow up inspection. [s. 9. (1)]

Issued on this 14 day of November 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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) : JESSICA LAPENSEE (133) - (A1)

Inspection No. / No de l'inspection : 2016_346133_0031 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 023484-15 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Nov 14, 2016;(A1)

Licensee / Titulaire de permis : CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : MANOIR MAROCHEL
949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sharon Gilmour

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

To CVH (No.4) GP Inc. as general partner of CVH (No.4) 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_346133_0029, CO #001;

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 :

In order to achieve compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c), the licensee will prepare, submit and implement a detailed plan that provides for:

a) A full audit of all resident bedrooms and common areas, including all surfaces (i.e. walls, floors), fixtures (i.e. lights, sinks, toilets, windows), equipment (i.e. call bell system activation cords) and furnishings.

b) Correcting all items captured by the licensee's full home audit, and all specifically identified areas of concern within the grounds that support this order, including, but not limited to: windows, resident washroom floors, hallway floors and lights. Corrective actions are to be documented.

c) An ongoing process to ensure the home's ongoing remedial maintenance needs are identified, documented and addressed in a timely manner. Corrective actions are to be documented.

d) A written process to follow and address identified ongoing issues, such as flooring that will not remain adhered to the subsurface in hallways and in washrooms, and loud exhaust fans. As a component of the heating, ventilation and air conditioning system, the individual exhaust fans throughout the home are to be cleaned, maintained and inspected in accordance with O. Reg. 79/10, s. 90 (2) (c).

e) A comprehensive mentoring and support program for the new Maintenance Supervisor, that will ensure adherence with the home's written procedures related to maintenance of the home, including any/all required documentation, and to ensure compliance with the LTCHA, 2007, S.O. 2007, c.8, s. 15 (2) and s. 15 (2) (c), and O. Reg. 79/10, s. 90.

This order must be complied with by November 14th, 2016.

The compliance plan is due for October 12th, 2016. The plan may be emailed to Inspector #133's attention at the following email address: OttawaSAO.MOH@ontario.ca. Alternately, the compliance plan may be faxed to the Inspector's attention at (613) 569-9670 or mailed to 347 Preston Street, Suite 420, 4th floor, Ottawa, Ontario, K1S 3J4.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, c. 8, s. 15 in that 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.

The licensee has a history of non-compliance in this area. As a result of the Resident Quality Inspection, #2014_198117_0032, conducted in December 2014, a Voluntary Plan of Correction was issued, and the licensee was served with an immediate Compliance Order (CO). As a result of Other inspection #2015_346133_0005, conducted in February 2015, the licensee was served with a Compliance Order (CO #001), with a compliance date of July 20, 2015. As a result of Follow Up inspection #2015_346133_0029, conducted in August 2015, the licensee was served with a Compliance Order (CO #001), with a compliance date of August 22, 2016. Written notifications were issued, as additional evidence for the Compliance Order (CO) due for August 22, 2016, as a result of Follow Up inspection #2015_346133_0040 (WN # 1) in October 2015, Resident Quality Inspection #2015_286547_0025 (WN # 15) in December 2015, and Follow Up inspection #2016_346133_0027 (WN# 2) in July 2016.

The home's former Administrator, who was also the designated lead for the maintenance program, left the home in early August 2016. The home was being covered by an acting Administrator, available by phone and email, at the time of the inspection. The home's maintenance worker, #S103, began working at the home in early May 2016. He was confirmed as the permanent Maintenance Supervisor on August 30th, 2016, during the inspection. In this role, he is the designated lead for the maintenance services program as per O. Reg. 79/10, s. 92. He is referred to as the Maintenance Supervisor (MS) throughout this report.

On August 31st, 2016, related to the requirement within the CO to implement a routine auditing program to ensure sustained adherence to the home's written procedures related to maintenance of the home, the MS advised that he was not aware of such a program. Although aware of some of the corrective actions taken in response to the CO, the MS did not have the background to review and discuss the CO with the Inspector. A progress report submitted by the former Administrator on December 10th, 2015, in response to the CO, stated that "ongoing supervision is in place and a routine auditing program is in place via the designated lead". The Inspector was unable to gather any further information about this over the course of

the inspection.

The MS explained that he had recently been made aware, by the Extendicare Assist Regional Director with responsibility for the home, #S106, that there were policy manuals in the home for him to review, which outlined the routines that should be followed with regards to the maintenance program. He explained he had looked through some of them, over the course of the inspection, and was aware of the need to implement a preventative maintenance program. He explained that he was not following any of the manuals, and that he was only finding time to respond to immediate day to day maintenance needs, because there was so much work to do. As well, he was not finding the time to write anything down, yet he knew this was necessary in order to document actions taken. The MS indicated that he was aware of a few main ongoing problems at the home, such as floors, windows, doors (see written notification #3 in the associated inspection report) and the roof. Related to the roof, there had been flooding at the home, in some bedrooms, in early August 2016. Final corrective actions were being taken by the roofing company over the course of the inspection.

On August 30th, 2016, the Extendicare Assist Regional Director with responsibility for the home, #S106, did inform the Inspector, via email communication, that there was an orientation plan for the new MS.

The following observations were made over the course of the Follow Up inspection, August 29th – 31st, 2016. Ongoing non-compliance was observed, specifically with regards to windows and floors.

Resident bedroom windows:

Bedroom #116 – Resident #003's window was in poor repair. There was a very heavy accumulation of condensation between the panes of the openable window and the upper window seal was hanging loosely, in pieces, between the panes. There was accumulation of rusted pieces of the seal between the panes, along the base, and rust along the lower area of the panes.

Bedroom #110 – The window was in poor repair. There was heavy accumulation of condensation between the panes of the openable window, there were streaks of rust running down the panes, and the inner seal around the panes was cracked and rusty.

Bedroom #131 – Within the bed space on the left side of the bedroom, the window was in poor repair. There was accumulation of condensation between the panes of the openable window, the inner seal had crumbled apart, with pieces of the seal stuck to the upper area of the panes and accumulation of the crumbled seal along the base.

Within the bed space on the right side of the bedroom, the window was in poor repair. There was accumulation of condensation between the panes of the openable window. There were streaks of rust running down the panes. There was accumulation of rust and parts of the crumbled seal along the base of the panes.

Bedroom #141 – The window was in poor repair. There was accumulation of condensation between the panes of the openable window. The inner seal had crumbled and pieces of it were stuck to the panes. There was accumulation of rust and parts of the crumbled seal along the base of the panes.

Note: Resident #003's window, in bedroom #116, was specifically referenced in the Compliance Order served as a result of Follow Up inspection #2015_346133_0029, conducted in August 2015. The licensee was ordered to implement a repair/replacement plan for all resident bedroom windows that were in poor repair, for August 22nd, 2016. On July 12th, 2016, a progress report submitted by the former Administrator stated that 42 small windows and 10 large windows had been replaced. The MS was not able to speak to how the former Administrator decided which windows needed to be replaced. The MS stated that there were approximately 10 more windows that needed to be replaced.

Resident washroom floors:

Bedroom #130 – In the washroom, the vinyl sheet flooring had shrunk and there was a loss of adhesion between the flooring and the concrete slab. The affected area was behind the toilet and along the wall next to the toilet, between the toilet and the wall. The edge of the flooring had pulled away from the baseboards, creating a gap of approximately half an inch. Accumulated dirt and debris was observed within the gap. The loose flooring was raised throughout the affected area.

Bedroom #106 – In the washroom, the vinyl sheet flooring had shrunk and there was a loss of adhesion between the flooring and the concrete slab. The affected area

was the full length of the wall to the side of the sink, under the sink and counter, and along the wall to the left of the doorway. The edge of the loose flooring was raised, along the wall to the left of the doorway. The gap between the strip of white wood at the base of baseboard and the edge of the flooring ranged from half an inch to three quarters of an inch. In the past, in an effort to manage this ongoing issue, the former maintenance supervisor had installed a strip of white wood along the base of the vinyl baseboard, around the perimeter of the washroom. This was done in order to close the gap and keep the edges down. The flooring had since regressed.

Bedroom #121/#123 – In the shared washroom, under, in front of and beside the sink, the vinyl sheet flooring was not adhered to the concrete slab beneath. The loose flooring was raised throughout the affected area and there was a small gap between the flooring and the baseboard under the sink and to the side of the sink.

Note: The floor in washroom #130 was specifically referenced in the Compliance Order served as a result of Follow up inspection #2015_346133_0029, conducted in August 2015 and this overall issue was first described in the Compliance Order served as a result of Other inspection 2015_346133_0005. In the past, the Inspector has been informed that this ongoing issue is a result of excess moisture within the concrete slab beneath the flooring, as there is no sub floor.

West hallway floors:

In the short length of the west hallway, there were approximately 10 areas where the vinyl sheet flooring was not adhered to the concrete slab below. As a result, the flooring was raised and bubbled, in the centre of the hallway, presenting a potential tripping hazard for residents. All raised areas were approximately three to four inches wide and half an inch in height. The most notable area, between the tub room and shower room, in the center of the hallway, was approximately three feet in length. There were four to five shorter raised areas in the immediate proximity. There were two raised areas in the hallway, between bedrooms #125 and #131, approximately 16 inches in length each. After bedrooms #131 and #125, there was one area that was approximately two feet in length. Two subsequent areas, towards bedrooms #127 and #129, were 20 inches and 22 inches in length respectively. Between these last two raised areas, there was a cut in the flooring.

While observing this area on August 31st, 2016, Registered Practical Nurse #S108

told the Inspector that she was not aware that any resident had tripped on the raised areas, but felt there was potential for tripping, and that overall it was a danger for the residents.

Outside of bedroom #133, closer to the opposite wall, there was one large raised curved area. The area measured two feet, from tip to tip, and was approximately four to five inches wide.

Between bedrooms #115/#145 and #119/#141, there were numerous raised areas. The areas were along the sides of the hallway as well as in the center. The areas ranged in length from four inches, up to 23 inches (between bedrooms #117 and #147). The raised areas were all approximately three inches wide and an inch and a half in height. There was a raised area between bedroom #117 and #115, towards the center of the hallway. There were several raised areas between bedrooms #117 and #119, towards the side of the hallway. There were raised areas directly in front of bedroom #143 and between bedroom #143 and #145. There was a raised area directly outside of bedroom #121, to the left side if within the bedroom. There were raised areas between bedroom #139 and #137. Along the edge of the hallway, between bedrooms #113 and #115, under the handrail, there were several smaller raised areas.

Note: The raised areas in the short length of the west hallway were specifically referenced in Written Notification (WN) #2, issued as a result of Follow Up Inspection #2016_346133_0027, in July 2016. The WN was issued as additional evidence in support of Compliance Order #001, associated to Follow Up inspection #2015_346133_0029, conducted in August 2015, which also described loose hallway flooring in the area of bedrooms #119, #145 and #115. It is noted that raised flooring directly in front of these three bedrooms was replaced. In the past, the Inspector has been informed that this ongoing issue is a result of excess moisture within the concrete slab beneath the flooring, as there is no sub floor. The Maintenance Supervisor informed that following the inspection in July 2016, he was told by the former Administrator that he could cut the raised areas in the short length of the west hallway in an effort to flatten them. He pointed out that the two raised areas closest to bedroom #127 and #129 had a cut between them, but this had not prevented the flooring from raising up on either side of the cut. He did not feel that cutting the raised areas was a suitable solution.

Lights:

Bedroom #112 – One of the two fluorescent tube lights in the ceiling mounted fixture within the immediate entrance to the bedroom was burnt out and the other one was very dim.

Bedroom #122 – The lens for the two lights on the wall above the bedroom door, connected to the resident-staff communication and response system, was missing. This lens enhances the lights, helping staff to see where the call for assistance is coming from more effectively.

Bedroom #102 – The lower fluorescent tube light in the wall mounted light fixture above the bed was flickering and was very dim.

Bedroom #127 – The lens for the fluorescent tube light fixture on the ceiling in the washroom was missing.

Bedroom #125 – The lens for the fluorescent tube light fixture on the ceiling within the immediate entrance to the bedroom was missing.

Bedroom #133 – The upper fluorescent tube light in the wall mounted light fixture above resident #006's bed was not functional.

Hallway lights – The fluorescent tube lights in the ceiling mounted fixture outside of bedroom #151 and #109 were very dim.

Bedroom #101 - The lens for the fluorescent tube light fixture on the ceiling within the immediate entrance to the bedroom was missing.

Hallway lights – Between bedrooms 134/132 and 106/108, one of the fluorescent tube lights in the ceiling mounted fixture was burnt out and one was extremely dim.

Bedroom #135 – The metal bead chain pull cord for the light fixture above resident #008's bed was very short, with only approximately four beads remaining. The Inspector was able to turn the lights on by pulling repeatedly on the short chain, but could not turn the lights off.

Other:

Bedroom #114 – There was no screen for the window.

Bedroom #128 – The wall to the left of the washroom door was deeply gouged in several areas. The lower outer washroom door was extensively scuffed and scraped. The outer washroom door frame, on the left, paint was scraped down to the metal.

The wall divider between the two bed spaces was damaged; the lower wall surface was broken and chipped away.

Bedroom #131 – The lower wall to the right of resident #005's bedside table was in poor repair. There was a large indentation in the wall surface, above the baseboard, and the baseboard had been forced inwards. There was a gap between the floor tile and the baseboard, with accumulation of debris within the gap. Above this area, mid wall, there was one straight gouge line.

The resident's closet door was in poor repair. On the lower area of the outer closet door, the wood was broken and splintered.

Note: Resident #005's closet door was specifically referenced in the Compliance Order (CO) served as a result of Follow up inspection #2015_346133_0029, conducted in August 2015. The CO required that such damaged surfaces be remediated by November 24th, 2015. A progress report submitted by the former Administrator on December 10th, 2015 noted that the then maintenance supervisor has rejoined service (following a leave) and regular maintenance along with documentation was taking place. It stated that wall remediation was ensured via the routine maintenance program. The progress report did not specifically address resident #005's closet.

South tub room – the drain cover was missing for the floor drain, to the right of the tub.

South dining room – The wall under the windows was in poor repair. The wall under the middle window was scraped along a horizontal length with paint peeling around it. The paint under the window on the left was peeling and the wall was scuffed. The wall under the window on the right has a long length of black scuffing. The lower inner dining room door was extensively scraped and the frame on the right was scraped down to the metal. The lower wall, on the right, upon entry to the dining room, was gouged and scuffed.

Bedroom #108 – The towel bar next to the sink, in the washroom, was missing. The right bracket for the towel bar remained in place, affixed to the wall, but the left bracket was missing.

Bedroom #110 – The bathroom exhaust fan was very loud, making a deep rattling sound.

Note: It has been previously established (inspection #2015_346133_0005, CO #001 and #2015_346133_0029, CO #001) that the exhaust is so loud in some resident bathrooms because the individual fans are old and the blades dulled. When an old fan is replaced with a new fan, the exhaust is rendered almost silent. There are times when the bathroom exhaust only comes on when the light is turned on, and other set times when the exhaust runs automatically. It has been previously established that when the exhaust comes on automatically and the bathroom door is open, and there is an old fan in place which is loud, it can be disruptive to residents as they rest. A progress report submitted by the former Administrator on December 10th, 2015 noted that three noisy exhaust fans had been replaced and that further replacement of fans would be done as required.

The home's current Maintenance Supervisor indicated that he was not aware of a replacement program for the exhaust fans

Bedroom #A - On August 30th, 2016, it was observed that the cover for the toilet tank was sitting across the toilet seat and the flushing mechanism was inoperable. Resident # 007 told the Inspector that she/had to use the toilet in the main lobby if she/he needed to have a bowel movement, and hoped her/his toilet would be fixed that day. A housekeeper, #S107, told the Inspector that she had discovered that this toilet was broken on August 29th, 2016, had reported it to the Maintenance Supervisor (MS) upon discovery, and had reminded him about it on that day (August 30th, 2016). Towards the end of the inspection day, on August 31st, 2016, the MS explained that he had found a replacement flushing mechanism for this toilet in the maintenance room, and that the toilet was now functional. Resident #007 had to use the toilet in the main lobby for three days.

West dining room: The wall under the third window (from entrance) was cracked and peeling. The area had been partially patched. The wall under the first window was cracked and indented in two areas above the baseboard and was scuffed all around

the damaged area.

The widespread nature of the observed non-compliance observed, the potential risk to residents presented by some of the non-compliance and the licensee’s history of non-compliance related to maintenance requires a subsequent Compliance Order (CO) be issued. As well, as this will be the fourth CO served to the licensee pursuant to LTCHA, 2007, s. 15 (2) (c), a referral to the Director will be made.
(133)

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

Dec 05, 2016(A1)

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 14 day of November 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa