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 sous *la Loi de 2007 sur les foyers de soins de longue durée***

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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 16, 2019 | 2019_630589_0010 | 015790-17, 018880-17, 028531-17, 002601-18, 003676-18, 003910-18, 005929-18, 005974-18, 006502-18, 011683-18, 016664-18, 016862-18, 022597-18, 026675-18, 026718-18, 027841-18, 028123-18, 033431-18, 001952-19, 004855-19 | Critical Incident System |

### Licensee/Titulaire de permis

Providence St. Joseph's and St. Michael's Healthcare
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

Providence Healthcare
3276 St. Clair Avenue East SCARBOROUGH ON M1L 1W1

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

JOANNE ZAHUR (589), ARIEL JONES (566), ORALDEEN BROWN (698), STELLA NG (507)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): March 18, 19, 20, 21, 22, 25, 26, 28, 29, April 1, 2, 3, 4, 5, and 8, 2019.**

**The following intakes were completed during this inspection:**
**-logs #001952-18/C544-000002-18, #027841-18/C554-000065-18, #026718-18/C554-000062-18, #026675-18/C554-000063-18, #022597-18/C554-000057-18 related to falls prevention,**
**-#033431-18 related to an environmental hazard,**
**-#019245-18/C554-000052-18, #007577-18 and #011683-18/C554-000035-18 related to financial abuse,**
**-#01664-18/C554-000035-18, #003910-18/C554-0000010-18, and #015790-18/C554-000027-18 related to injury of unknown cause,**
**-#006502-18/C554-000014-18, #005974-18/C554-000008-18, #005929-18/C554-000011-18, #002601-18/C554-000005-18 related to infection control/outbreaks,**
**-#003676-18/C554-000009-18, #028531-17/C554-0000067-17 related to alleged physical abuse, and**
**-#018880-17/C554-000032-17 related to visitor abuse, and**
**-#030693-18 related to compliance order #001 follow-up regarding abuse from inspection #2018_462600_0013.**

**Written Notification related to LTCHA, 2007, S. O. 2007, C.8, s. 19 (1) identified in concurrent inspection #2019_630589_0009, (log #031593-18) will be issued in this report.**

**Written Notification and a Voluntary Plan of Correction related to LTCHA,2007, S.O. 2007, C.8, s. 6. (7), identified in concurrent inspection #2019_642698_0004, (logs #026885-17, #021510-17, #016549-17, and #014244-17) will be issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Care Manager (RCM), Resident Care Supervisors (RCS), Registered Staff (RN/RPNs), Resident Assistants (RA), Agency RA, Physician, Infection Prevention and Control Practitioner (IPAC-P), Housekeeping Services (HS), Activation Assistant (AA), Private Caregiver (PC), Informatics Specialist (IS), Physiotherapist (PT), Building Services and Security**

**Manager (BSSM), Residents, and Substitute Decison Makers (SDM).**

**During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, medication administration, and the provision of care, reviewed health records, the home's internal investigation notes, staff training records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**

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

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

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

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

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

**Findings/Faits saillants :**

The licensee has failed to ensure that resident #006 was protected from abuse by

anyone.

A critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in regards to a financial abuse allegation against a staff member.

A review of the CIS report and the home's investigation notes indicated resident #006 had reported to the long term care home (LTCH) that staff #122 had asked resident #006 whether they would like to play the lotto and asked them for money on two occasions. Resident #006 stated they gave money to staff #122 to purchase the lotto tickets because staff #122 told them they had a method/scheme on how to win. Resident #006 stated they were told by staff #122 that they did not win on the first occasion and that staff #122 did not show them the lotto tickets purchased that had not won.

A further review of the CIS report indicated that during an interview with staff #109, staff #122 denied asking for money from resident #006. Staff #122 stated resident #006 gave them money to buy lotto tickets for them on two occasions. Staff #122 told resident #006 that they did not win and showed resident #006 the lotto tickets that had not won. On the second occasion, staff #122 did not buy lotto tickets with resident #006's money, and the money was returned to resident #006 after the above mentioned meeting with staff #109. This was confirmed by an interview with staff #109.

During an interview, resident #006 stated they did not remember the incident of giving staff money to buy lottery tickets.

Staff #122 was absent from the home during the inspection, therefore an interview was not conducted.

During an interview, staff #109 stated staff #122 was reassigned to another RHA when the home became aware of the above mentioned incident. After the internal investigation, staff #122 was given a discipline regarding the above mentioned incidents. Staff #122 was also asked to review and complete the Surge Learning module on the home's Abuse/ Neglect of Resident policy, Residents' Rights and the home's Mission and Values.

During an interview, staff #109 confirmed resident #006 had not been protected from financial abuse by staff. [s. 19. (1)]

2. The licensee has failed to ensure that resident #005 was not neglected by the licensee

or staff.

The licensee's previous compliance history indicated a compliance order had been served in report #2018_462600_0013 under O. Reg. 79/10, s. 19 (1) of the LTCHA, with a compliance date of December 31, 2018. The order indicated the licensee must provide a plan that should include but not be limited to:
A) the development and implementation of a process for communication among direct care staff including:
i. monitoring of residents with change in condition,
ii. conducting assessments, communicating findings, applying intervention, and documenting the outcomes of the interventions for residents who experience a change in a condition.

On February 28, 2019, a CIS report was submitted to the MOHLTC regarding concerns raised by resident #005's SDM related to care provided to the resident.

A review of the CIS report indicated staff #109 made a call to resident #005's SDM and during the call, the SDM raised several care concerns regarding resident #005.

During an interview, resident #005's SDM stated that private staff #142 attended to resident #005 during identified hours throughout the week. On an identified date in February 2019, resident #005's SDM was informed by private staff #142 that the resident was experiencing a change in their health status.

A review of resident #005's health record stated that the resident was admitted to the home with multiple health conditions including a chronic health condition. A further review of resident #005's progress notes indicated that the resident had been diagnosed with an illness in February 2019, and received treatment.

The progress notes also indicated that resident #005 remained on precautions on an identified date in February 2019, as they continued to exhibit  symptoms of the above mentioned illness, despite receiving treatment.

A review of resident #005's progress notes indicated that on an identified date in February 2019, the resident was sent to hospital as they were experiencing a change in their health status. A review of the hospital discharge summary indicated that resident #005 was admitted to the hospital with a diagnosed health condition and passed away while in hospital.

A review of resident #005's electronic medication administration record (eMAR) indicated the resident was prescribed medications to manage an identified health condition to be given as prescribed and as needed.

During an interview, staff #115 stated that on an identified date in February 2019, they had checked on resident #005 shortly after shift report. The resident responded to staff #115 when their name was called and was not in distress. Approximately one hour later, staff #115 checked resident #005 again and administered the scheduled morning medication as ordered and stated resident #005 was not in any distress or discomfort at the time. During the midday medication pass, resident #005's private staff #142 approached and informed staff #115 that resident #005 was experiencing a change in condition. Staff #115 continued with their medication administration pass and did not assess the resident nor did they offer the resident the prescribed as needed (PRN) medication.

During an interview, private staff #142 stated that resident #005 had been fine in the morning. Shortly before lunch time, they observed that resident #005 was experiencing a change in their health condition. Private staff #142 approached staff #115 and informed them that resident #005 was not well. Private staff #142 further stated that resident #005's health condition remained unchanged when they left at the end of their shift. Private staff #142 also stated that resident #005 had not been assessed by a nurse since they had reported a change in their health condition.

A review of the 24 hour summary report for the RHA indicated there was no mention of resident #005's change in health condition.

During an interview, staff #119 stated that as the incoming shift they did not receive a report from outgoing shift staff that resident #005 was experiencing a change in health condition. Staff #119 stated they had checked on resident #005 twice during their shift and they did not appear to be in any discomfort or distress during those observations however later in the shift, staff #119 was alerted by staff #118 that resident #005 was not well. Staff #119's assessment and observations indicated resident #005 was experiencing a change in their health condition and was sent to hospital.

During an interview, staff #115 confirmed that on an identified date in February 2019, they had checked on resident #005 twice during their entire shift. Staff #115 also confirmed that on the same day, when resident #005's private staff had reported a

change in condition they had not offered the PRN medication nor endorse resident #005's change in condition to the oncoming staff.

A review of the home's "Decision Tree – Acute Change of Condition" protocol indicated that all residents are at risk for acute changes in condition. When there are symptoms recognized as change in health status/ condition, RPNs should assess, monitor, initiate immediate interventions and document. RPNs should contact RNs as needed and ensure all notifications (including contacting SDM) and documentation are completed.

During an interview, staff #109 confirmed that staff #115's inaction to resident #005's change of condition was evidence of failure to provide the resident with the treatment, care, services or assistance required for the resident's health, safety or well-being which jeopardized the resident's health, safety or well-being. [s. 19. (1)]

3. A CIS report was submitted to the MOHLTC related to an incident of witnessed staff to resident abuse. The CIS report indicated that staff #113 had been in the hallway outside resident #010's room when they heard two sounds coming from resident #010's room. Upon entering the room staff #113 observed staff #166 providing care to resident #010, speaking loudly to the resident and witnessing the staff member hit the resident. Staff #113 stated that resident #010 was exhibiting a verbal sound but did not have resident #010's face in their line of vision to observe for any signs of discomfort. A further review of the CIS indicated staff #113 instructed the RA to stop giving care and to leave the room. Upon leaving the room, the RA insisted the noise heard by staff #113 was the linen cart lid closing.

During an interview, staff #113 stated that staff #166 did not know they were standing in the room as the floor is carpeted. Staff #113 further stated that they heard and saw RA #166 raising their voice towards resident #010 and hitting them. After telling staff #166 to leave the room, staff #113 instructed another RA to complete care to resident #010 and for the RPN to complete a head to toe assessment. A review of the progress notes for resident #010 noted an entry documented by staff #148 indicating no apparent injuries noted at that time.

A review of resident #010's health record indicated they were admitted to the LTCH with multiple underlying health conditions that included impaired cognition and ability to verbalize. A review of an assessment completed for resident #010 at the time of the incident indicated cognitive impairment affecting short term and long term memory, and no memory recall.

During an interview, resident #023 who had been resident #010's roommate at the time of the incident acknowledged they had heard staff #166 hit resident #010 on previous occasions but did not know who to report it to. Resident #023 stated that the noise had woken them up that night. Staff #113 also verified that resident #023 had also disclosed to them that staff #166 had hit resident #010 on previous occasions.

A review of the LTCHs internal investigation indicated they had determined an act of physical abuse had occurred and as a result staff #166's employment was terminated therefore, an interview was not conducted.

During an interview, staff #113 acknowledged that the actions of staff #166 indicated they had failed to ensure residents were protected from abuse by the licensee or staff in the home. [s. 19. (1)]

4. The following evidence related to resident #020 was found under inspection report 2019_630589_0009.

The MOHLTC received a complaint indicating that on an identified date in November 2018, there had not been a resident assistant (RA) working on an identified shift on an identified RHA. The complaint also indicated that care had not been provided to 19 residents on that shift.

A review of the resident census for November 2018, indicated there were 17 residents residing on this RHA. A review of the daily scheduling roster indicated two agency RAs were booked, one for the a designated RHA and the second was booked for a special assignment with resident #013. A review of the point of care screens (POC) for the above noted shift indicated that, except for resident #013, the remaining 16 residents had not received any care that shift.

During an interview, staff #103 stated that upon starting their shift they had answered a couple of call bells on the other RHA and had also observed there was no RA there as the linens had not been picked up. Staff #103 further stated that after responding to the two call bells they went to their own assignment and did not return back to the other RHA.

A review of the LTCHs registered nurse routine practice expectations indicated they are to ensure all units are staffed, collaborate with the team for staff assignments, if needed

and to update daily staff assignments.

A review of email correspondence between staff #107 and staff #109 indicated that staff #110 called the switchboard operator (SO) to inform then they had received a call from staff #127 stating they had not shown up for their shift. The SO then informed staff #110 that this RAs name was not on the schedule. During a phone conversation, staff #110 stated they had worked the identified shift and was in charge of two identified RHAs. Staff #110 further stated they could not clearly remember the events however did indicate that the RA should have been responsible to tell them where they had been scheduled to work and it was not their responsibility to ask as SO would only have looked at the staffing schedule for the floors they were in charge of that shift.

Staff #107 and staff #109 acknowledged the above noted email correspondence as accurate.

During an interview, staff #114 stated they had worked the identified shift in November 2018, and was in charge of the two identified RHAs. Staff #114 further stated that on initial rounds they had observed two RAs, and assumed the resident home areas (RHAs) was staffed accordingly. Staff #114 was not aware that one of the RAs they had observed was doing a special assignment with resident #013. Staff #114 also stated they had not spoken to either of these two RAs to confirm their assignments.

A review of the call bell history for that identified shift indicated that the call bells were all directly accepted by staff #114. The call bell history did not indicate which residents had used the call bells. In a conversation, staff #114 stated the fact the RA was not answering call bells did not alert them to confirm the RAs presence on RHA.

During an interview, staff #124 stated that when they arrived for their shift, they would usually observe the previous shift's RA completing their POC documentation but, on this day they did not see anyone. Staff #124 further stated that staff #103 informed them there had not been a RA working on that RHA all shift. Staff #124 then indicated they asked staff #114 if they knew there had not been a RA working on the identified RHA, informing them that many of the residents were found to be incontinent more than usual. Staff #114 acknowledged they had not known until that moment and had assumed the RA standing at the end of the hallway had been the assigned staff member for that RHA.

During an interview, staff #125 stated that upon arriving for their shift they had been informed by staff #124 that there had not been a RA working on the previous shift. Staff

#125 further stated that the residents in their assignment were found to be incontinent more than usual and that resident #009 had informed them that no one had come to provide care to them. Both staff #124 and #125 stated there had not been any incidence of altered skin integrity noted during morning care.

During a conversation, resident #009 recalled there had been a shift in November 2018, where no RA had entered their room to provide care however they could not recall the actual date and if they had been incontinent. A review of resident #009's care plan in place at the time of this incident indicated under the continence focus that the RA is to check and change the incontinent product on rounds during the shift.

During an interview, staff #109 acknowledged that on the identified date in November 2018,16 residents did not receive care related to no RA working and therefore there was as the failure to provide residents with treatment, care, services or assistance required for their health, safety, well-being. [s. 19. (1)]

***Additional Required Actions:***

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

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

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

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

A CIS report was submitted to the MOHLTC regarding concerns raised by resident #005's substitute decision-maker (SDM) related to care provided to resident #005.

A review of the CIS report indicated staff #109 made a call to resident #005's SDM and during the call, they raised a concern regarding not receiving the results of a diagnostic test that had been completed. During an interview, resident #005's SDM stated that resident #005 had a diagnostic test completed and that they had not been notified of the results.

A review of resident #005's diagnostic test results indicated the presence of a new health condition. A review resident #005's physician's orders indicated to repeat the diagnostic test in an identified period. This was confirmed during an interview with staff #126.

During interviews, staff #117 and staff #126 stated that when staff receive diagnostic test reports, staff would place the non-urgent reports on the doctor's communication clip board for the doctor to review during their next visit. For reports that require immediate attention, staff would notify the doctor immediately.

A review of the LTCHs "Registered Nurse Routine Practice Expectations, revised May 30, 2017" stated that two of the RNs scope of practice and expectations are as follow:
-when the Physician is present, participate in rounds and assist/ support processing and verifying doctor's written orders, and
-in collaboration with the RPN, communicate with residents/ families to get consent and any changes in health status.

During an interview, staff #117 stated that the doctor's repeat order for the diagnostic test for resident #005 was processed after the doctor's rounds. Staff #117 also stated they did not call resident #005's SDM after the order was processed.

During an interview, staff #109 stated that when registered staff process a doctor's order, they should notify the resident and/ or the resident's SDM of any changes of treatment/ interventions and the reason for the ordered treatment/ interventions. Staff #119 confirmed that resident #005's SDM had not been notified of resident #005's diagnostic test results and of the physician's order to repeat, as required. [s. 6. (5)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to

the resident as specified in the plan.

A CIS report was submitted to the MOHLTC related to an incident of witnessed staff to resident abuse. The CIS report indicated that staff #113 had been in the hallway outside resident #010's room and heard sounds coming from there. Upon entering the room staff #113 observed an identified RA providing personal care to resident #010, raisng their voice and hitting them.

A review of resident #010's health record indicated they were admitted to the LTCH with multiple underlying health conditions that included cognitive impairment and inability to express themselves. A review of an assessment completed for resident #010 at the time of the incident indicated cognitive impairment. Under physical functioning the assessment indicated resident #010 required the assistance of two staff for bed mobility. A review of the plan of care in place at the time of the above mentioned incident and at the time of the inspection, indicated under the focus of bed mobility that two staff are required to provide this aspect of their care. A review of an assessment completed at the time of this incident indicated under personal care, that resident #010 required total dependence with two staff assistance.

During an interview, staff #113 acknowledged that when they observed RA at resident #010's beside they were providing care unassisted by a second RA. Staff #113 acknowledged that care set out in the plan of care was not provided to resident #010 as specified in their plan. [s. 6. (7)]

3. The following evidence related to resident #003 was found under inspection report 2019_642698_0004.

A complaint was received by the MOHLTC related to resident #003 from their SDM. The complaint indicated concerns related to several care areas, with one in particular being, the one to one (1:1) staffing not being in place when a private caregiver was with resident #003.

During an interview with the inspector, the SDM indicated that the LTCH was not providing 1:1 staffing when the private caregiver hired by them was in the home

A review of the staff assignment for an identified date in September 2017, indicated resident #003 did not have 1:1 monitoring during an identified shift for an identified eight hour period. The care plan indicated resident #003 exhibited responsive behaviors, was

at high risk for falls/injuries, and required 1:1 staff monitoring at all times for an identified 16 hour period daily. A further review of the staff schedule regarding 1:1 staff over a two week period from August 2017, to September 2017, indicated that 1:1 staffing had not been consistent during that time period.

A review of resident #003's care plan indicated a Providence LTCH sitter was provided through the MOHLTC's High Intensity Needs (HIN) to monitor their responsive behaviors, high risk for falls/injuries, and that staff were to remain with the resident at all times.

During an interview, staff #107 stated that when there is no staff available for 1:1 staffing, the other staff members scheduled to work are made aware so that they can monitor the resident every 15 minutes or half an hour. [s. 6. (7)]

***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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

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

While waiting to conduct an interview with staff #148, the inspector observed this RPN conducting the days to evening narcotic shift count alone.

Observations by the inspector indicated staff #148 had placed several narcotic medication cards on top of the medication cart while completing the narcotic count.

A review of the home's policy titled: Shift Change Monitored Drug Count, policy number HP156, last revised August 14, 2018, indicated under the procedure section that from days to evening shift, two registered staff (one outgoing and one incoming) together are to:
-count the actual quantity of medications remaining,
-record the date, time, quantity of medication and sign in the appropriate spaces on the "shift change monitored medication count" form,
-confirm the actual quantity is the same as the amount recorded on the individual monitored medication record,
-if a discrepancy is found during the count, nurses must review and follow-up on the findings, and
-any resolved discrepancy is to be reported immediately to the resident care manager or Director of Resident Care or delegate.

During an interview, staff #105 who was the outgoing day registered staff stated that staff #148 was late for their shift so they had conducted the narcotic count alone. When staff #148 arrived staff #105 informed them the count was correct and then left the medication room leaving staff #148 there alone. Staff #105 acknowledged that their actions were not acceptable and that the narcotic count should have been completed by two registered staff, one incoming staff and one outgoing staff.

During an interview, staff #148 indicated they were aware that the narcotic count should have been completed with staff #105 as the outgoing staff member, as per the home's policy.

During an interview, staff #111 acknowledged that the actions of staff #105 and #148 had been inappropriate and indicated they had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place had been implemented. [s. 8. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

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

1) a) A CIS report was submitted to the MOHLTC in regards to an incident that caused an injury to resident #019 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and resident #019's progress notes indicated the RAs lowered resident #019 to the floor to prevent them from falling. The RAs then assisted the resident into a mobility aid.

Over a two day period, resident #019 was assessed by registered staff on two occasions as they were exhibiting signs of verbal and non-verbal discomfort. As well, after being assessed by the on-call doctor, resident #019 was sent to the hospital for further assessment, where they were diagnosed with an injury.

During an interview, staff #145 stated that resident #019 had refused to be transferred with a mobility aid, which was reported to staff #164. Staff #164 told staff #145 to then transfer resident #019 in their usual method. Staff #145 asked for assistance of staff #116, and they transferred resident #019 from their bed to a mobility aid manually. During the transfer, the staff members had to lower resident #019 onto the floor.

A review of an assessment completed for resident #019 indicated they were totally dependent and required two or more persons physical assist for transfers, and that the resident required to be lifted using a mechanical aid.

A review of resident #019's written plan of care indicated that resident #019 was unable to weight bear, required two person total assistance using a mechanical aid for transfers and that the transfer aid size was located in the Point of Care (POC).

During an interview, staff #109 confirmed that staff did not follow resident #019's care plan, and did not use safe transferring devices or techniques when assisting resident #019.

b) A CIS report was submitted to the MOHLTC in regards to an incident that caused an injury to resident #019 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

Observations by the inspector indicated staff #143 and #144 transferring resident #019 from their bed to a mobility aid using a mechanical transfer aid and a transfer aid with a yellow hem.

A review of resident #019's written plan of care indicated that the resident did not weight bear, and required two persons total physical assistance with transferring using a mechanical aid. The care plan also indicated the transfer aid size was located in Point of Care (POC). A further review of resident #005's POC stated that the resident required an identified transfer aid size, and this was confirmed in an interview with staff #144.

During an interview, staff #144 was not able to tell the inspector the size of the transfer

aid used for the above mentioned transfer as there was no label attached to it. However, staff#144 stated they were sure the transfer aid used was the correct one because it had been placed on the hook with the resident's name in the shared washroom.

2) Resident #030 was selected as a result of non-compliance identified with resident #019.

Observations by the inspector indicated the transfer aid placed on the hook with resident #030's name in the shared washroom had a red hem.

A review of resident #030's written plan of care completed indicated that the resident required mechanical aid for transfers, and the resident's POC stated that the resident required an identified transfer aid size for transfers.

During an interview, staff #143 was not able to tell the inspector the size of the above mentioned transfer aid as there was no label attached to it. However, staff #143 stated they were sure the above mentioned transfer aid was the correct one because it had been placed on the hook with the resident's name in the shared washroom.

3) Resident #031 was selected as a result of non-compliance identified with resident #019.

Observations by the inspector indicated the transfer aid placed on the hook with resident #031's name in the shared washroom had a red hem.

A review of resident #031's written plan of care indicated that the resident required mechanical aid for transfers, and the resident's POC stated that the resident required an identified transfer aid size for transfers.

During an interview, staff #156 was not able to tell the inspector the size of the above mentioned transfer aid as there was no label attached to it. However, staff #156 stated they were sure the above mentioned transfer aid was the correct one because it had been placed on the hook with the resident's name in the shared washroom.

During interviews, staff #143, #144 and #156, staff #154, staff #117 and staff #165 were not able to identify the sizes of the transfer aids by colour codes.

A review of the sizing guide tool from the LTCHs supplier of transfer aids, provided to the

inspector by the staff #155 indicated the colour codes for the different sizes of transfer aids was.

During an interview staff #119 acknowledged the following:
-resident #019 required an identified transfer aid size for mechanical transfers, and that the incorrect size had been used, and
-residents #030 and #031 required the same identified transfer aid sizes for mechanical transfers, and that the incorrect sizes, had been used. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

While waiting to conduct an interview with staff #148, the inspector observed the staff member leave the medication room open and unattended.

Observations by the inspector indicated staff #148 had several narcotic medication cards on top of the medication cart, the key for the narcotic bin was left in the lock leaving the bottom drawer slightly open. Further observations indicated staff #148 momentarily left the medication room without safely storing the narcotic cards, locking the narcotic bin or closing th medication room door. When staff #148 walked to the nursing station approximately 20 steps away they had their back to the medication room, therefore the open door was not within their line of vision. While staff #148 was at the nursing station, resident #029 walked by the unattended and open medication room, looked in but did not attempt to enter.

During an interview, staff #148 indicated they had removed the narcotic medication cards from the narcotic bin and placed them on top of the medication cart while conducting the narcotic count. Staff #148 also acknowledged that by leaving the medication room unsecure to make an inquiry with staff #105 at the nursing station, that this was not safe medication practice.

During an interview, staff #111 acknowledged that the actions of staff #148 indicated the home had failed to ensure that drugs were stored in an area or a medication cart that was secure and locked. [s. 129. (1) (b)]

***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 controlled substances is stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

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

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the MOHLTC regarding an incident that caused an injury to resident #019 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

A review of the CIS report and resident #019's progress notes indicated that during a transfer, the staff members lowered resident #019 to the floor to prevent them from falling. Then the staff members assisted the resident into a mobility aid.

A review of resident #019's heath record indicated there was no assessment completed after the above mentioned incident.

Staff #164 remains employed by the LTCH however has not worked over the past six months, therefore an interview was not conducted.

During an interview, staff #109 stated an assessment should be completed after a resident has fallen. Staff #109 confirmed an assessment was not completed after resident #019's fall. [s. 49. (2)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was submitted to the MOHLTC related to an incident of witnessed staff to resident abuse.

A review of the CIS report indicated that resident #010's SDM was notified of the above mentioned incident of witnessed abuse on the next day, nearly 15 hours later.

During an interview, staff #113 stated they had not notified the SDM the same night acknowledging that they should have.

During an interview, staff #109 acknowledged that the home had failed to notify resident #010's SDM within 12 hours of becoming aware of the witnessed incident of abuse. [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A CIS report was submitted to the MOHLTC related to an incident of witnessed staff to resident abuse.

A review of the amended CIS report indicated the family member was to be notified of the outcome of the home's internal investigation.

During an interview, staff #109 could not recall informing resident #010's SDM of the home's investigation and if they had, this would have been documented in the CIS report and in the progress notes. A review of the progress noted did not reveal an entry regarding the SDM being notified of the outcome. Staff #109 acknowledged that it was highly likely they had not spoken to resident #010's SDM regarding the outcome of their internal investigation immediately upon the completion. [s. 97. (2)]

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 sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Issued on this 18th day of April, 2019**

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

**Original report signed by the inspector.**

Ontario

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

**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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JOANNE ZAHUR (589), ARIEL JONES (566), ORALDEEN BROWN (698), STELLA NG (507) |
| **Inspection No. / No de l'inspection :** | 2019_630589_0010 |
| **Log No. / No de registre :** | 015790-17, 018880-17, 028531-17, 002601-18, 003676-18, 003910-18, 005929-18, 005974-18, 006502-18, 011683-18, 016664-18, 016862-18, 022597-18, 026675-18, 026718-18, 027841-18, 028123-18, 033431-18, 001952-19, 004855-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Apr 16, 2019 |
| **Licensee / Titulaire de permis :** | Providence St. Joseph's and St. Michael's Healthcare<br>3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1 |
| **LTC Home / Foyer de SLD :** | Providence Healthcare<br>3276 St. Clair Avenue East, SCARBOROUGH, ON, M1L-1W1 |

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 :** Pat Colucci

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To Providence St. Joseph's and St. Michael's Healthcare, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_462600_0013, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with LTCHA, 2007, s. 19 (1).

The licensee must specifically ensure the following:
1) That all registered staff implement the communication process previously developed, amongst themselves, and at shift report that includes:
a) Development and implementation of a process for communication among direct care staff including:
i. monitoring of residents with change in condition, and
ii. conducting assessments, communicating findings, applying interventions, and documenting the outcomes of the interventions for residents who experience a change in a condition.
2) Develop and implement an auditing tool to monitor staff compliance with assessments, intervention implementation and documentation when there is a change in resident condition, and
3) Maintain a written record of the audits completed that includes the date, resident name, name of staff member completing the audit, and the action taken as a result of the audit outcome.

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #005 was not neglected by the licensee or staff.

Under O. Regulation 79/10, s. 5 for the purpose of the definition "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of

inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee has failed to comply with compliance order #001 from inspection #2018_462600_0013 issued on September 19, 2018, with a compliance date of December 31, 2018.

The licensee was ordered to prepare, submit and implement a plan to ensure every resident is protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.
The plan should include but not limited to:
a) Development and implementation of a process for communication among direct care staff including:
i. monitoring of residents with change in condition,
ii. conducting assessments, communicating findings, applying intervention, and documenting the outcomes of the interventions for residents who experience a change in a condition,
b) A description of the training and education that will occur related to prevention of abuse and neglect including:
i. what constitute abuse and neglect including the definition as per the LTCHA, 2007, failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and inaction or a pattern of inaction that jeopardizes the health, safety or well-being of residents,
ii. the home's policy for abuse and neglect,
iii. to ensure that all direct care staff is trained, understand and confirm an understanding of the different types of abuse and neglect and common forms of abuse and neglect in long-term care.

The licensee completed steps b), i, ii, and iii.

The licensee failed to complete steps a), i, and ii.

The licensee has failed to ensure that resident #005 was not neglected by the licensee or staff.

The licensee's previous compliance history indicated a compliance order had been served in report #2018_462600_0013 under O. Reg. 79/10, s. 19 (1) of the

LTCHA, with a compliance date of December 31, 2018. The order indicated the licensee must provide a plan that should include but not be limited to:
A) the development and implementation of a process for communication among direct care staff including:
i. monitoring of residents with change in condition,
ii. conducting assessments, communicating findings, applying intervention, and documenting the outcomes of the interventions for residents who experience a change in a condition.

On February 28, 2019, a CIS report was submitted to the MOHLTC regarding concerns raised by resident #005's SDM related to care provided to the resident.

A review of the CIS report indicated staff #109 made a call to resident #005's SDM and during the call, the SDM raised several care concerns regarding resident #005.

During an interview, resident #005's SDM stated that private staff #142 attended to resident #005 during identified hours throughout the week. On an identified date in February 2019, resident #005's SDM was informed by private staff #142 that the resident was experiencing a change in their health status.

A review of resident #005's health record stated that the resident was admitted to the home with multiple health conditions including a chronic health condition. A further review of resident #005's progress notes indicated that the resident had been diagnosed with an illness in February 2019, and received treatment.

The progress notes also indicated that resident #005 remained on precautions on an identified date in February 2019, as they continued to exhibit symptoms of the above mentioned illness, despite receiving treatment.

A review of resident #005's progress notes indicated that on an identified date in February 2019, the resident was sent to hospital as they were experiencing a change in their health status. A review of the hospital discharge summary indicated that resident #005 was admitted to the hospital with a diagnosed health condition and passed away while in hospital.

A review of resident #005's electronic medication administration record (eMAR) indicated the resident was prescribed medications to manage an identified health condition to be given as prescribed and as needed.

During an interview, staff #115 stated that on an identified date in February 2019, they had checked on resident #005 shortly after shift report. The resident responded to staff #115 when their name was called and was not in distress. Approximately one hour later, staff #115 checked resident #005 again and administered the scheduled morning medication as ordered and stated resident #005 was not in any distress or discomfort at the time. During the midday medication pass, resident #005's private staff #142 approached and informed staff #115 that resident #005 was experiencing a change in condition. Staff #115 continued with their medication administration pass and did not assess the resident nor did they offer the resident the prescribed as needed (PRN) medication.

During an interview, private staff #142 stated that resident #005 had been fine in the morning. Shortly before lunch time, they observed that resident #005 was experiencing a change in their health condition. Private staff #142 approached staff #115 and informed them that resident #005 was not well. Private staff #142 further stated that resident #005's health condition remained unchanged when they left at the end of their shift. Private staff #142 also stated that resident #005 had not been assessed by a nurse since they had reported a change in their health condition.

A review of the 24 hour summary report for the RHA indicated there was no mention of resident #005's change in health condition.

During an interview, staff #119 stated that as the incoming shift they did not receive a report from outgoing shift staff that resident #005 was experiencing a change in health condition. Staff #119 stated they had checked on resident #005 twice during their shift and they did not appear to be in any discomfort or distress during those observations however later in the shift, staff #119 was alerted by staff #118 that resident #005 was not well. Staff #119's assessment and observations indicated resident #005 was experiencing a change in their health condition and was sent to hospital.

During an interview, staff #115 confirmed that on an identified date in February 2019, they had checked on resident #005 twice during their entire shift. Staff #115 also confirmed that on the same day, when resident #005's private staff had reported a change in condition they had not offered the PRN medication nor endorse resident #005's change in condition to the oncoming staff.

A review of the home's "Decision Tree – Acute Change of Condition" protocol indicated that all residents are at risk for acute changes in condition. When there are symptoms recognized as change in health status/ condition, RPNs should assess, monitor, initiate immediate interventions and document. RPNs should contact RNs as needed and ensure all notifications (including contacting SDM) and documentation are completed.

During an interview, staff #109 confirmed that staff #115's inaction to resident #005's change of condition was evidence of failure to provide the resident with the treatment, care, services or assistance required for the resident's health, safety or well-being which jeopardized the resident's health, safety or well-being. [s. 19. (1)]

The severity of this issue was determined to be a level 3, meaning actual harm/risk to resident #005, the scope was determined to be a level 1 as was only related to resident #005. The previous compliance history was determined to be a level four, meaning ongoing non-compliance related to a compliance order served in report #2018_462600_0013 under LTCHA, 2007, s. 19 (1) of the LTCHA, with a compliance date of December 31, 2018. (507)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 20, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 16th day of April, 2019**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Joanne Zahur

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