Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 04, 2021	2020_678590_0013 (A2) (Appeal\Dir#: DR# 140)	014839-20, 015023-20, 016792-20, 016903-20, 018241-20, 019372-20, 019769-20, 019887-20	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue London ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue Amherstburg ON N9V 1E7

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

Amended by Lynne Haves (Director) - (A2)(Appeal\Dir#: DR# 140)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#002,CO#003.
The Director's review was completed on January 04, 2021.
Order(s) CO#003 was/were rescinded to reflect the Director's review DR# 140
Order(s) CO#002 was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 140.
A copy of the Director Order is attached.

Issued on this 4 th day of January, 2021 (A2)(Appeal\Dir#: DR# 140)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 04, 2021	2020_678590_0013 (A2) (Appeal/Dir# DR# 140)	014839-20, 015023-20, 016792-20, 016903-20, 018241-20, 019372-20, 019769-20, 019887-20	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue London ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue Amherstburg ON N9V 1E7

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

Amended by Lynne Haves (Director) - (A2)(Appeal/Dir# DR# 140)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 15 - 17, 29,

30, October 1, 2, 5, 6 and 8, 2020.

The following intakes were completed in this complaint inspection:

Log #016903-20 was related to responsive behaviours and medications;

Log #014839-20 was related to skin, wound and nail care, minimizing of restraints, resident rights and visitation procedures;

Log #015023-20 was related to an allegation of abuse;

Log #016792-20 was related to the visitation procedures;

Log #019372-20 was related to concerns about the visitation procedures, short stay absence procedures and resident rights;

Log #018241-20 was related to the minimizing of restraints, bed rails and the visitation procedures;

Log #019887-20 was related to the visitation procedures;

Log #019769-20 was related to the visitation and short stay absence procedures and resident rights.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Director of Care, the Director of Programs and Support Services, a Clinical Services Manager, a Social Worker, five Registered Practical Nurses, seven Personal Support Workers, one Housekeeper, three Quality Care Aides, the Manager of Environmental Health at the Windsor Essex Public Health Unit, eight family members and two residents.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, staff and resident interactions, the outdoor

visiting procedure, the provision of resident care, resident rooms and their general appearance, housekeeping routines and the general cleanliness and maintenance of the home.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, email correspondence and written policies and procedures relevant to inspection concerns.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **3 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's right to be cared for as needed was fully promoted and respected as the resident was placed into isolation after a medical outpatient appointment.

COVID-19 Directive #3 for Long-Term Care Homes (LTCH's) under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 by the Chief Medical Officer of Health. The Directive has been revised as necessary and the date of issuance and effective date of implementation of June 10, 2020, was the Directive in effect at the time of the incident.

A memo was sent out to LTCH's dated June 11, 2020, from the Ministry of Health (MOH), Ministry of Long-Term Care (MLTC) and Ontario Health (OH), to supplement the updated Directive #3 stating a revised admittance policy was effective immediately. The MLTC admissions and re-admissions policy stated that there were no restrictions on residents returning to the home from outpatient visits.

The home was not required to isolate the resident after their appointment and meal while outside the home. There were no restrictions on residents returning to the home from outpatient visits and the policy did not state that masks could not be removed to eat during outpatient visits.

In July, 2020, resident #005 was assisted by their substitute decision-maker (SDM) to attend an outpatient visit. Upon returning the resident to the home, the SDM reported to staff that they had provided a meal to the resident after their appointment. The SDM said that they had practiced the previously instructed infection prevention and control (IPAC) measures identified by the home when they departed for the appointment. As a result of these actions, the resident was put into isolation for two weeks for the reason of removing their mask to eat while outside of the home.

In an interview with the Windsor Essex Public Health Unit's Manager of Environmental Health, they supported that resident's may take their masks off, only to eat while outside of the home, as long as strict IPAC measures are followed by the resident and those around them. They clarified that a resident should not be isolated for that specific reason, especially if the only area of concern was that the mask was removed for meal. They said that if there was any more risk, for example, being at a social event where numerous people were not wearing masks or a high risk of infection in the community at the time of the incident, then the home should obviously isolate the resident. Further, they stated that the risk of spreading infection in the area at the time of the incident in July, 2020, was not high. The home stated that it was an IPAC risk that the resident had removed their mask to eat while out, regardless of the precautions taken in this situation. The home stated that their own policies were clear that masks were not to be removed while outside the home, even to eat. The home encouraged the person responsible for the resident while out, to return the resident to the home to eat food prepared by them if they needed to eat, and then go back out to their activities and then return the resident back to the home when the outing was finished.

Sources: Directive #3 (dated June 10, 2020); Resident #005's progress notes; MOH, MLTC & Ontario Health Memo - Re-introductions of Visits & Transfer of Hospital Patients and Community Clients to LTC Homes dated June 11, 2020; LTCH's policy titled Short Stay & Temporary Absence from Manual: Infection Control COVID-19 Pandemic, Section: Programs and Services; a LTCH document

titled Temporary and Short Stay Absences Guidelines; interviews with RPN #114 and other staff; interview with the Manager of Environmental Health at the Windsor Essex Public Health Unit. [s. 3. (1) 4.]

2. A) The licensee has failed to ensure that resident #005, 006 and 007's right to receive visitors of their choice was respected.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 by the Chief Medical Officer of Health.

Directive #3 requires homes to have a visitor policy in place that is compliant with the Directive. Directive #3, dated June 10, 2020, stated that the home was required to have a process for gradual resumption of family visitors that stipulated that visits should be pre-arranged and that family visitors to begin with one visitor at a time. This version of the Directive was in place at the time of resident #005's incident.

The Directive has been revised as necessary and the most recent date of issuance and effective date of implementation of September 9, 2020, was in effect at the time of the incidents involving resident #006 and #007. Directive #3 contains requirements related to managing visitors. The Directive states that the aim of managing visitors is to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life.

On September 2, 2020, the Ministry further released MLTC Resuming Visits in Long-Term Care Homes policy; and specifies that a caregiver is a type of essential visitor who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident (e.g., supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity and assistance in decision-making). Caregivers must be at least 18 years of age. A maximum of 2 caregivers may be designated per resident at a time. The designation should be made in writing to the home. Homes should have a procedure for documenting caregiver designations. The decision to designate an individual as a caregiver is entirely the remit of the resident and/or their substitute decision-maker and not the home. Examples of caregivers include family members who provide meaningful

connection, a privately hired caregiver, paid companions and translators.

Further, Ontario Regulation 146/20 under the Reopening Ontario Act - A Flexible Response to COVID-19, directed that beginning July 24, 2020, a long-term care provider must ensure that any employee who performs work in a long-term care home is not also performing work,
a. in another long-term care home operated or maintained by the long-term care provider;
b. as an employee of any other health service provider; or as an employee of a retirement home.

Complaints were received by the MLTC from the SDM of resident's #005, 006 and 007. The SDM's were concerned that the home denied them the opportunity to be essential caregivers to the residents, based on the grounds that they worked in another health care facility during the pandemic. They all shared that other than their places of employment, they have not been in contact with any other person's suspected of COVID-19, nor have they visited any other LCTH's. They all shared that they would voluntarily not visit the home if they were feeling unwell or displaying symptoms, as this would put other residents at risk.

A complaint received in September, 2020, identified and further confirmed in a progress note documented that one of resident #005's family members would be considered the only essential caregiver at that time. In an interview with the Director of Programs and Support Services #111 they said that this specific SDM's request to be an essential caregiver had been denied verbally and was because they worked in a heath care facility. They further indicated that the home also denied this request due to the resident already having one other essential care giver.

In a second complaint in September, 2020, resident #007's SDM's written request to be an essential caregiver was denied because they worked in a health care facility.

A third complaint received in September, 2020, identified that resident #006's SDM's request for essential caregiver was denied verbally by the home as they worked in a health care facility.

In interviews with the Interim Administrator, the DOC and the Director of Programs and Support Services, they all stated that the home was declining to allow people

who work in other health care facilities to be essential caregivers for their residents at this time during the pandemic for IPAC reasons.

Directive #3 did not provide restrictions that healthcare workers could not be considered essential caregivers for a resident, only that they could be employed at one healthcare setting. As per Directive #3 and the Resident's Bill of Rights under the LTCHA, resident #005, 006 and 007 family members should have been able to visit with the resident as an essential visitor.

The home did not have an outbreak of COVID-19 during July, August or September, 2020, when the complaints were lodged. In an interview with the Windsor Essex Public Health Unit's Manager of Environmental Health, they said that the area had not been at high risk of transmitting COVID-19 during that time. Based on the overall circumstances, the licensee did not have a basis to deny resident #005, 006, 007, a visit from their essential caregivers. With respect to an essential visitor, there was no basis to deny these visits in its entirety.

Accordingly, the licensee failed to ensure that resident #005, 006 and 007's right to have an essential care giver of their choice visit.

Sources: Directive #3 (dated June 10, 2020 and September 9, 2020); Ontario Regulation 146/20 under the Reopening Ontario (A Flexible Response to COVID-19) Act, 2020, July 24, 2020; LTCH's Social and Essential Visitors Policy, Reference No. 011001.00; MOLTC Resuming Visits in Long-Term Care Homes released September 2, 2020, in effect September 9, 2020; resident #007's Consideration for Essential Caregiver Program form and resident #005's progress notes; interviews with the Interim Administrator and other staff members; interview with the Manager of Environmental Health at the Windsor Essex Public Health Unit.

B) The licensee has failed to ensure resident #006's right to communicate in confidence and consult in private was respected during a visit with a family member to be informed of a family member's death.

In September, 2020, Clinical Services Manager #117 was responsible for supervising a visit between resident #006 and their family member. The staff member had sat outside the door and quietly and momentarily, visualized the visitor and resident every couple of minutes throughout the visit. As a result of these actions, the family member reported that the visit with the resident had been

uncomfortable and that the homes rules about supervising visits were overbearing given the circumstances.

Resident #006 and their family member had not been provided with adequate privacy during a visit to speak of difficult news. Directive #3 did not provide instruction that visits must be supervised by staff members, only that IPAC must be maintained during visits. Staff member #117 said that the homes policy directed them to supervise visits from a respectful distance to ensure that IPAC practices and social distance were maintained. The staff member said that while they assisted the family member with putting on their personal protective equipment (PPE), they were discussing rules of the visit and that they were already aware that the door would remain open during the visit for monitoring purposes. The staff member further reported no concerns with the abilities of the resident or the family member to maintain the appropriate IPAC practices during their visit in order for constant privacy to be provided.

The manner in which the LTC home supervised this visit did not fully respect and promote resident’s right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

Sources: Directive #3 (dated September 9, 2020); LTCH’s Social and Essential Visitors Policy, Reference No. 011001.00; MOLTC Resuming Visits in Long-Term Care Homes released September 2, 2020; LTCH documents titled Phase 4: Indoor Visiting Home Guidance (in effect September 9, 2020) and Phase 4 Visiting Guidelines; interview with Clinical Services Manager #117 and other staff members.

C) The licensee has failed to ensure that their designated area for outdoor visits provided privacy for residents' when visiting with others.

The MLTC received a complaint about the outdoor visiting area and process that was developed at the home when visits in LTCH's were initiated in June. The complaint was that they had to visit resident #010 through a fence, it was overly distanced and that they were not close enough to see or hear each other. They reported that the visit was provided no privacy as it had been constantly supervised, they stood beside the parking lot for the visit and they had to use walkie talkies to hear each other.

The outdoor visiting area in question was observed on October 8, 2020, along

with the current outdoor visiting areas, by the inspector and Director of Programs and Support Services #111 to assess the appropriateness and alternative arrangements that could have been made for privacy during the visits during that time frame.

Richmond Terrace has a large secured outdoor setting with a pathway and several benches spaced far apart. There is a covered outdoor area that has a pond with fishes, they have a gazebo, and another cement pad near the road where a wheelchair can be parked to watch the traffic. Each of the visiting areas used along the path were spaced apart sufficiently to enjoy a private conversation with someone who had no hearing impairments, even if not requested. At the time of the complaint though, the visits were conducted with the residents being brought out to the courtyard and positioned on the sidewalk facing the parking lot for the visit. The visitors would stay outside of the courtyard on the sidewalk, with the tall iron fence outlining the secured courtyard in between them during the visit. There was a grass boulevard located in between the residents sidewalk and the fence, and the space between the sidewalk and fence was at least six feet apart.

The home shared that they were not made aware of any privacy concerns with their initial outdoor visiting area set-up. Director of Programs and Support Services #111 stated that this was the outdoor setting and process that the home had developed and felt was safest for them to manage at the time and that the visiting area had been moved into the courtyard within the last three weeks. The Director of Programs and Support Services #111 further stated that they recognized that privacy in the initial setting may have been an issue for some people, but if they had been aware of a need for privacy or if it was requested by any resident or visitor, that an appropriate private setting would have been provided in a timely manner. The Director of Programs and Support Services #111 shared that every visit was visually supervised from a respectful distance to ensure that IPAC practices were maintained throughout the visit and that some staff may appear to be monitoring the visit in close proximity, in order to physically assist the resident with something, if needed.

In an interview with the Windsor Essex Public Health Unit's Manager of Environmental Health, they said that the area had not been at high risk of transmitting COVID-19 during the months of June through September, 2020.

Sources: Observation of the initial outdoor visiting area; interview with Director of Programs and Support Services #111 and other staff members; interview with the

Manager of Environmental Health at the Windsor Essex Public Health Unit; document titled Final Richmond Terrace Outside Visits Plan - Connection Cubes dated June 12, 2020; document titled Appendix A - Rules for Outside Family Visits - Connection Cube Encounters; MOLTC Resuming Visits in Long-Term Care Homes released September 2, 2020. [s. 3. (1) 14.]

3. The licensee has failed to fully promote resident #010's right to leave the building for a short stay absence with a family member of their choice that has not had a COVID-19 test.

Resident #010's SDM had not been allowed to take the resident out of the home for an afternoon visit, because they have not have a COVID-19 test done. They had attempted to take the resident from the home for afternoon visits during the months of August and September 2020. They questioned the home's practice and contacted the MLTC for clarification on the rules related short-stay absences and COVID-19 testing requirements.

The Interim Administrator stated they have gone above and beyond their policy to safeguard their residents and are declining to allow people that have not been tested for COVID-19 to take a resident out of the home. The home stated that their short stay policy is in compliance with the Directives and is what is best, IPAC speaking, for all the residents in the home. In an interview with the Manager of Environmental Health at the Windsor Essex Public Health Unit, they stated that the area was not considered high risk for community spread at the time.

Sources: Interviews with Interim Administrator and other staff members; Policy Subject: 'Short Stay & Temporary Absence', from the Infection Control COVID-19 Pandemic manual, from section titled Programs and Services. Directive #3: Date of Issuance: September 9, 2020. Effective Date of Implementation: September 9, 2020. [s. 3. (1) 23.]

Additional Required Actions:

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

(A2)(Appeal/Dir# DR# 140)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 002,003

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was dressed in clean clothing and appropriately for the hot weather during their outdoor visit.

Resident #005 had a scheduled outdoor visit with their substitute decision maker (SDM) in September 2020. The SDM reported that the resident was brought to their visit late. When the resident was brought to the SDM the resident was wearing a coffee stained shirt and their lap was covered with a thermal blanket. As a result of this, the visit did not last the minimum 30 minutes, the visit had not been enjoyable for the SDM or the resident and the resident required the administration of Tylenol for a low-grade fever. The resident had not been provided the assistance needed to be clothed in a manner consistent with their needs.

The Quality Care Aide (QCA) that transported the resident to their visit did not ensure that appropriate help was provided to change the resident's shirt before their visit. QCA #118 said that they brought resident #005 down to their visit wearing the stained shirt and a blanket because there was no help for the resident around. The QCA said that they probably would have been upset if their loved one was presented to them in this condition.

Sources: Resident #005's progress notes; interviews with QCA #118, 119 and 120; interview with RPN #115. [s. 40.]

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 residents are dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's area of impaired skin was assessed weekly.

The resident had a chronic area of impaired skin integrity as a result of a medical diagnosis. During the COVID-19 visitor restrictions the Substitute Decision-Maker (SDM) was concerned that the area was getting worse and that staff were not monitoring it or taking appropriate action. Upon review of the resident's completed assessments, no assessments were located for the skin impairment.

The registered staff members did not complete or document weekly assessments on the chronic area of impaired skin. The registered staff interviewed shared they were aware of the requirement to complete weekly assessments on areas of impaired skin as per their policy, but did not assess this particular area as it was chronic in nature and was located where they saw it everyday.

The lack of documented weekly assessments did not enable to the home effectively track and monitor the impaired area of skin for changes.

Sources: Resident #005's progress notes and care plan; Skin and Wound Management Policy, effective January 2011, and supersedes May 1, 2003; Registered Nurse Association of Ontario Best Practice Guideline Risk Assessment and Prevention of Pressure Ulcer dated 2005, and Pressure Ulcer; and interviews with Registered Practical Nurse (RPN) #114 and other staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 4 th day of January, 2021 (A2)(Appeal/Dir# DR# 140)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Lynne Haves (Director) - (A2) (Appeal/Dir# DR# 140)
Inspection No. / No de l'inspection :	2020_678590_0013 (A2)(Appeal/Dir# DR# 140)
Appeal/Dir# / Appel/Dir#:	DR# 140 (A2)
Log No. / No de registre :	014839-20, 015023-20, 016792-20, 016903-20, 018241-20, 019372-20, 019769-20, 019887-20 (A2) (Appeal/Dir# DR# 140)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 04, 2021(A2)(Appeal/Dir# DR# 140)
Licensee / Titulaire de permis :	Richmond Terrace Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Richmond Terrace 89 Rankin Avenue, Amherstburg, ON, N9V-1E7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Scott

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Richmond Terrace Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must comply with s. 3 (1) 4. of the LTCHA.

Specifically the licensee must:

Ensure that no residents are unnecessarily isolated.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that resident #005's right to be cared for as needed was fully promoted and respected as the resident was placed into isolation after a medical outpatient appointment.

COVID-19 Directive #3 for Long-Term Care Homes (LTCH's) under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 by the Chief Medical Officer of Health. The Directive has been revised as necessary and the date of issuance and effective date of implementation of June 10, 2020, was the Directive in effect at the time of the incident.

A memo was sent out to LTCH's dated June 11, 2020, from the Ministry of Health (MOH), Ministry of Long-Term Care (MLTC) and Ontario Health (OH), to supplement the updated Directive #3 stating a revised admittance policy was effective immediately. The MLTC admissions and re-admissions policy stated that there were no restrictions on residents returning to the home from outpatient visits.

The home was not required to isolate the resident after their appointment and meal while outside the home. There were no restrictions on residents returning to the home from outpatient visits and the policy did not state that masks could not be removed to eat during outpatient visits.

In July, 2020, resident #005 was assisted by their substitute decision-maker (SDM) to attend an outpatient visit. Upon returning the resident to the home, the SDM reported to staff that they had provided a meal to the resident after their appointment. The SDM said that they had practiced the previously instructed infection prevention and control (IPAC) measures identified by the home when they departed for the appointment. As a result of these actions, the resident was put into isolation for two weeks for the reason of removing their mask to eat while outside of the home.

In an interview with the Windsor Essex Public Health Unit's Manager of Environmental Health, they supported that resident's may take their masks off, only to eat while outside of the home, as long as strict IPAC measures are followed by the resident and those around them. They clarified that a resident should not be isolated for that specific reason, especially if the only area of concern was that the mask was removed for meal. They said that if there was any more risk, for example, being at a social event where numerous people were not wearing masks or a high risk of infection in the community at the time of the incident, then the home should obviously isolate the resident. Further, they stated that the risk of spreading infection in the area at the time of the incident in July, 2020, was not high. The home stated that it was an IPAC risk that the resident had removed their mask to eat while out, regardless of the precautions taken in this situation. The home stated that their own policies were clear that masks were not to be removed while outside the home, even to eat. The home encouraged the person responsible for the resident while out, to return the resident to the home to eat food prepared by them if they needed to eat, and then go back out to their activities and then return the resident back to the home when the outing was finished.

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

Sources: Directive #3 (dated June 10, 2020); Resident #005's progress notes; MOH, MLTC & Ontario Health Memo - Re-introductions of Visits & Transfer of Hospital Patients and Community Clients to LTC Homes dated June 11, 2020; LTCH's policy titled Short Stay & Temporary Absence from Manual: Infection Control COVID-19 Pandemic, Section: Programs and Services; a LTCH document titled Temporary and Short Stay Absences Guidelines; interviews with RPN #114 and other staff; interview with the Manager of Environmental Health at the Windsor Essex Public Health Unit.

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

Severity: There was minimal risk of harm to the resident when their right to be cared for was not respected and they were isolated unnecessarily after their medical outpatient appointment.

Scope: The scope was widespread as the homes policy and practice applied to all residents, including, but not limited to resident #005.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 3 (1) and two Written Notifications (WNs) and one Voluntary Plan of Correction (VPCs) were issued to the home.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 23, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

(A2)(Appeal/Dir# DR# 140)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or

refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

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

(A2)(Appeal/Dir# DR# 140)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or

refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 4 th day of January, 2021 (A2)(Appeal/Dir# DR# 140)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Lynne Haves (Director) - (A2)
(Appeal/Dir# DR# 140)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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