Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 20, 2021	2021_829757_0012	003931-21	Complaint

Licensee/Titulaire de permis

Sioux Lookout Meno-Ya-Win Health Centre
1 Meno-Ya-Win Way P.O. Box 909 Sioux Lookout ON P8T 1B4

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

William A. "Bill" George Extended Care Facility
75 Fifth Avenue Sioux Lookout ON P8T 1K9

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

DAVID SCHAEFER (757)

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): May 10-14 & 17, 2021.

The following intake was inspected during this complaint inspection:
-a complaint regarding concerns for multiple residents related to the safety of the home, infection prevention and control measures, improper use of equipment, medication administration, restraints, dining, and skin and wound care.

This Complaint inspection was conducted concurrently with Critical Incident System (CIS) inspection #2021_829757_0013.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator/Team Lead, Northwestern Health Unit (NWHU) Public Health Manager, NWHU Public Health Inspector, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), activation staff, housekeeper, dietary aide, residents, and the complainant.

The Inspector also conducted a daily tour or resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, resident-to-resident interactions, and reviewed relevant resident health care records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every use of a physical device to restrain three residents under s. 31 of the Act, the following was documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal of the device, including time of removal.

The Long-Term Care Homes Act (LTCHA), 2007, s. 31 (3), requires that for a resident who is being restrained by a physical device, the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; and any other requirements provided for in the regulations are satisfied.

Pursuant to Ontario Regulation (O. Reg.) 79/10, s. 110 (2), the licensee was required to ensure that for residents who were restrained by a physical device under s. 31 of the LTCHA, staff only applied a physical device that had been ordered or approved by a physician or registered nurse in the extended class; that staff applied the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class; that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; that the resident was released from the physical device and repositioned at least once every two hours; that the resident was released and repositioned any other time when necessary based on the resident's condition or circumstances; and that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

A complaint was received by the Director with concerns that proper restraints protocols were not being followed in the home. The care for three residents requiring restraints was reviewed during this inspection. The documentation for each of these residents was incomplete and missing key information such as the application and removal of the devices, and the times these actions occurred; the required hourly monitoring of residents; the required release and repositioning of residents that must occur at least every two hours; and the required assessments of the residents by a physician or registered nursing staff every eight hours. The home's staff acknowledged that this documentation was often missed or forgotten. The Administrator indicated that staff had not followed the home's restraints policy, and that this did not represent acceptable documentation of the care of these residents.

Sources: Residents' care plans and Point of Care (POC) restraints documentation; the home's "Policy of Least Restraint"; and interviews with the complainant, Administrator, and other relevant staff members. [s. 110. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, as it related to isolation requirements of residents admitted to the home.

Pursuant to Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, three residents admitted to the home during the COVID-19 pandemic were required to be placed under a mandatory 14-day isolation period in their rooms following their arrival to the home.

A complaint was received by the Director related to concerns that residents admitted to the home during the COVID-19 pandemic were not being isolated for 14-days as required, and that this posed a safety risk to other residents in the home. Direct care staff and management indicated that three residents admitted during the COVID-19 pandemic were difficult to maintain isolation measures for. The home's Team Lead stated that they eventually "gave up" and did not maintain isolation measures, or enforce staff to maintain them, prior to the completion of the 14-day isolation period. The Administrator indicated they did not complete individual plans for the three residents to complete 14-days of isolation in the home, as required under Directive #3.

Interviews with PSWs and RPNs indicated that efforts at maintaining the 14-day isolation for these residents were "short-lived" and indicated that within a week, management had not been enforcing isolation measures for two of the residents. During the 14-day period following their admission, the residents were assessed in common areas, permitted to leave their rooms and move throughout the home with other residents, and dine in the dining room with other residents. The third resident was permitted to dine in the dining room on their first day in the home, and a staff member indicated they were not isolated at all.

A manager at the Northwestern Health Unit (NWHU) indicated that the failure of the home to maintain the required 14-day isolation period for these residents posed a safety risk to other residents; and that the risk of a potential spread of COVID-19 throughout the

home could not be eliminated without maintaining the proper isolation period for the residents. They indicated that the NWHU had not been informed by the home of their failure to maintain the 14-day isolation period.

The home's Team Lead and Administrator acknowledged that they were aware of the potential risk of harm to other residents in the home if any of the three residents had been incubating a COVID-19 illness, despite their negative test prior to admission.

Sources: Three resident's progress notes; Chief Medical Officer of Health (CMOH) Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 (Dated December 7, 2020); and interviews with the complainant, NWHU Manager, Administrator, Team Lead, and other relevant staff members. [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used equipment in a resident's room in accordance with manufacturer's instructions.

A complaint was received by the Director related to concerns regarding a potential safety risk related to equipment in a resident's room being left on while not in use. Inspector #757 observed that the equipment had been left on in the resident's room while the resident and staff were not in the room and the equipment was not in use. Staff members indicated that the equipment was frequently left on while not in use, and that they were not aware it was supposed to be turned off between uses. The manual for the equipment indicated that it was not to be left unattended while plugged in, or left on while not in use.

Sources: Observations of a resident's room; equipment user manual; and interviews with the complainant and relevant staff members. [s. 23.]

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 staff use the equipment required for a resident's care in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #4: 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 when a resident exhibited altered skin integrity including skin breakdown and wounds, the resident received an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for wound assessment.

A complaint was received by the Director related to wound assessments for a resident. Both the home's Team Lead and RPNs indicated that the home's clinically appropriate assessment instrument that was specifically designed for wound assessment was the wound assessment tool located on the home's electronic MED e-care system. Registered nursing staff had not completed a wound assessment for this resident using this assessment instrument prior to the inspection, and instead had used progress notes which were not specifically designed for wound assessment.

Sources: A resident's progress notes and MED e-care assessments; interviews with the complainant, Team Lead, and other relevant staff members. [s. 50. (2) (b) (i)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive 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, to be implemented voluntarily.

Issued on this 9th day of June, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DAVID SCHAEFER (757)
Inspection No. / No de l’inspection :	2021_829757_0012
Log No. / No de registre :	003931-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 20, 2021
Licensee / Titulaire de permis :	Sioux Lookout Meno-Ya-Win Health Centre 1 Meno-Ya-Win Way, P.O. Box 909, Sioux Lookout, ON, P8T-1B4
LTC Home / Foyer de SLD :	William A. "Bill" George Extended Care Facility 75 Fifth Avenue, Sioux Lookout, ON, P8T-1K9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cynthia Dwyer

To Sioux Lookout Meno-Ya-Win Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must comply with s. 110 (7) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must prepare, submit, and implement a plan to ensure staff are following the home's "Policy of Least Restraint" and to ensure that the following is documented with regard to residents who require physical restraints:
- The application of the restraint device, including who applied it and the time of application.
- The removal of the restraint device, including the time of removal.
- Hourly monitoring of residents while in physical restraints.
- The release and repositioning of residents in physical restraints at least every two hours.
- Assessments of residents in physical restraints at least every eight hours, to be completed by a physician, registered nurse in the extended class, or a member of the registered nursing staff.

The plan must include but is not limited to:
- The type of retraining that will be provided to staff, including who will be responsible for the retraining, and when it will be completed.
- The person responsible for monitoring that the policy is being complied with, and that documentation is being completed per the legislative requirements outlined in O. Reg. 79/10, s. 110 (7).
- What follow-up action will be taken by the home when gaps in the required documentation of physical restraints are identified; and
- Any actions that will be taken by the home to ensure that compliance with O. Reg. 79/10, s. 110 (7) can be sustained once compliance has been achieved through the above actions.

Please submit the written plan for achieving compliance for inspection 2021_829757_0012 to David Schaefer, LTC Homes Inspector, MLTC, by June 4, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that for every use of a physical device to restrain three residents under s. 31 of the Act, the following was documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal of the device, including time

of removal.

The Long-Term Care Homes Act (LTCHA), 2007, s. 31 (3), requires that for a resident who is being restrained by a physical device, the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; and any other requirements provided for in the regulations are satisfied.

Pursuant to Ontario Regulation (O. Reg.) 79/10, s. 110 (2), the licensee was required to ensure that for residents who were restrained by a physical device under s. 31 of the LTCHA, staff only applied a physical device that had been ordered or approved by a physician or registered nurse in the extended class; that staff applied the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class; that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; that the resident was released from the physical device and repositioned at least once every two hours; that the resident was released and repositioned any other time when necessary based on the resident's condition or circumstances; and that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

A complaint was received by the Director with concerns that proper restraints protocols were not being followed in the home. The care for three residents requiring restraints was reviewed during this inspection. The documentation for each of these residents was incomplete and missing key information such as the application and removal of the devices, and the times these actions occurred; the required hourly monitoring of residents; the required release and repositioning of residents that must occur at least every two hours; and the required assessments of the residents by a physician or registered nursing staff

every eight hours. The home's staff acknowledged that this documentation was often missed or forgotten. The Administrator indicated that staff had not followed the home's restraints policy, and that this did not represent acceptable documentation of the care of these residents.

Sources: Residents' care plans and Point of Care (POC) restraints documentation; the home's "Policy of Least Restraint"; and interviews with the complainant, Administrator, and other relevant staff members. [s. 110. (7)]

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

Severity: There was minimal risk to residents as the failure to maintain the required documentation for residents in physical restraints resulted in the home being unable to determine what care was or was not actually provided to residents in restraints.

Scope: The scope of the issue was widespread as the home did not complete the required documentation related to the care of residents in physical restraints in three of the three residents' records reviewed during this inspection.

Compliance History: A Voluntary Plan of Correction (VPC) was issued to the home related to this subsection of the legislation in the past 36 months. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must comply with s. 5 of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

1) Ensure that residents admitted to the home throughout the COVID-19 pandemic, who are not exempt from mandatory isolation measures, are isolated per the requirements of the latest iteration of the Chief Medical Officer of Health (CMOH) Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, at the time of each resident's admission.

2) Develop, implement, and comply with a policy for the home related to the receiving of new admissions to the home, as well as for transfers of residents from other health care facilities back to the home, throughout the COVID-19 pandemic. The policy must include the development of individualized plans to isolate any residents admitted to the home, which are required to undergo mandatory isolation per Directive #3. The policy must address the management of challenges to isolation measures, including referrals related to responsive behaviours where measures taken by the home are ineffective at maintaining isolation.

3) Update the policy to coincide with any future iterations of CMOH Directive #3 for Long-Term Care Homes, and continue with this and the above measures until all iterations of the Directive have been rescinded.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, as it related to isolation requirements of residents

admitted to the home.

Pursuant to Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, three residents admitted to the home during the COVID-19 pandemic were required to be placed under a mandatory 14-day isolation period in their rooms following their arrival to the home.

A complaint was received by the Director related to concerns that residents admitted to the home during the COVID-19 pandemic were not being isolated for 14-days as required, and that this posed a safety risk to other residents in the home. Direct care staff and management indicated that three residents admitted during the COVID-19 pandemic were difficult to maintain isolation measures for. The home's Team Lead stated that they eventually "gave up" and did not maintain isolation measures, or enforce staff to maintain them, prior to the completion of the 14-day isolation period. The Administrator indicated they did not complete individual plans for the three residents to complete 14-days of isolation in the home, as required under Directive #3.

Interviews with PSWs and RPNs indicated that efforts at maintaining the 14-day isolation for these residents were "short-lived" and indicated that within a week, management had not been enforcing isolation measures for two of the residents. During the 14-day period following their admission, the residents were assessed in common areas, permitted to leave their rooms and move throughout the home with other residents, and dine in the dining room with other residents. The third resident was permitted to dine in the dining room on their first day in the home, and a staff member indicated they were not isolated at all.

A manager at the Northwestern Health Unit (NWHU) indicated that the failure of the home to maintain the required 14-day isolation period for these residents posed a safety risk to other residents; and that the risk of a potential spread of COVID-19 throughout the home could not be eliminated without maintaining the proper isolation period for the residents. They indicated that the NWHU had not been informed by the home of their failure to maintain the 14-day isolation period.

The home's Team Lead and Administrator acknowledged that they were aware of the potential risk of harm to other residents in the home if any of the three

residents had been incubating a COVID-19 illness, despite their negative test prior to admission.

Sources: Three resident's progress notes; Chief Medical Officer of Health (CMOH) Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 (Dated December 7, 2020); and interviews with the complainant, NWHU Manager, Administrator, Team Lead, and other relevant staff members. [s. 5.]

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

Severity: There was minimal risk because the failure of the licensee to maintain the 14-day isolation period for residents #005, #006, and #009, presented a risk of an incubating COVID-19 illness which had potential to be spread throughout the home to other residents.

Scope: The scope of the issue was widespread as the home did not maintain the required 14-day isolation for three of the three residents reviewed during this inspection, and because the potential for an incubating COVID-19 illness in any of these residents created a safety risk for all other residents in the home.

Compliance History: In the past 36 months, the licensee has no compliance history related to this section of the legislation. (757)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2021

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:

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

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 20th day of May, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : David Schaefer

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