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
Jul 28, 2021	2021_848748_0007	003468-21, 005267-21, 005297-21, 005981-21, 006314-21, 009072-21, 009467-21	Complaint

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Royal Rose Place
635 Prince Charles Drive North Welland ON L3C 0C7

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

EMMY HARTMANN (748)

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 28, May 31, June 2, 3, 4, 7, 8, 9, 10, 14, 15, 16, 17, 18, 21, 22, and 23, 2021.

The following intakes were completed during this inspection:

Log #003468-21 was related to falls prevention.
Log #005267-21 was related to CIS #3049-000005-21, fall of a resident that resulted in injury.
Log #005297-21 was related to falls prevention and infection control.
Log #005981-21 was related to staff to resident neglect, nutrition and hydration, skin and wound care, and continence care.
Log #006314-21 was related to CIS #3049-000009-21, alleged neglect of a resident resulting in death.
Log #009072-21 was related to skin and wound care.
Log #009467-21 was related to cooling requirements.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the acting Administrator, Director of Care (DOC), Infection Control Coordinator, Restorative Care Coordinator, Registered Dietitians, Culinary Manager, Nurse Managers, Rapid Antigen Tester, Screeners, Staffing Clerk, Receptionist, Niagara Region Public Health Inspector, Housekeepers, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents. The inspector also completed a tour of the home, and an Infection Prevention and Control (IPAC) checklist.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for residents that set out clear directions to staff and others who provided direct care to the residents.

A: A resident was deemed to be palliative on an identified date. Their progress note identified that they were not to be left unattended while in their mobility device.

On an identified date, the resident fell and sustained injuries. They were subsequently sent to hospital and diagnosed with an injury.

RN #112 identified that the resident was to remain in bed as they were palliative. Restorative Care Coordinator #113 identified that the resident was still able to use their mobility device. Nurse Manager #109 identified that the resident did not need assistance while they were in their mobility device, prior to their fall.

The resident's written care plan was reviewed and it did not include clear directions related to the resident's ambulation status, including the type of assistance they required.

Nurse Manager #109 and the DOC acknowledged the written care plan did not have clear directions to staff and others who provided direct care to resident #001.

There was a risk that the resident would not get the appropriate care related to their ambulation, due to the lack of clear directions to staff.

Sources: A resident's progress notes and care plan, interviews with RN #112, Restorative Care Coordinator, Nurse Manager #109, and DOC.

B: A resident's Continence Assessment documented on an identified date, indicated that the resident was incontinent.

Interview with PSW #122 identified that the resident was not toileted, and that they were changed according to the schedule in Point of Care (POC).

A review of resident #003's written care plan and POC tasks did not identify a schedule of when the resident's incontinent products were to be changed.

The DOC identified that the resident was changed before and after meals, and as requested; but verified that there was no schedule in the written care plan, and POC task.

There was a risk to the resident related to this non-compliance as there was no schedule of when their incontinent product was to be changed. The resident was at risk for not getting the appropriate care and assistance they needed related to continence care.

Sources: A resident's progress notes, assessments, POC task, and care plan; interview with PSW #122, and DOC. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care were reviewed and revised when two residents' care needs changed.

A: A resident was deemed palliative on an identified date. The resident was still able to use their mobility device but a risk of falling while using their device was identified. The resident was not to be left unattended while using their mobility device.

On an identified date, the resident fell and sustained injuries.

Restorative Care Coordinator #113 identified that they witnessed the fall, and that the resident was on their own with their mobility device.

The resident's care plan identified that they were high risk for falls, but the intervention of not being left alone while using their mobility device was not included in the list of interventions.

The DOC verified that the resident's plan of care was not updated.

There was harm to the resident related to this non-compliance, as the resident was left alone while using their mobility device, when they fell and was injured as a result.

Sources: A resident's progress notes and care plan, interview with Restorative Care Coordinator #113, and DOC.

B: A resident's progress notes identified that the resident had a change in condition. The doctor was notified and a diagnostic test was ordered.

RPN #125 was noted to have spoken with the resident's substitute decision maker (SDM) on the same day and was informed by the SDM that they wanted for the resident to be an identified intervention, to manage their condition.

The resident was sent to hospital on an identified date, and was admitted.

A review of the resident's written care plan did not include the intervention to manage their condition.

Interview with the Culinary Manager identified that there was no referral completed to dietary by nursing to include the intervention to the resident's plan of care, and that it was not added in the care plan as a result.

There was risk to the resident related to this non-compliance, as the resident continued to have their condition, including being hospitalized with an infection.

Sources: A resident's progress notes and care plan, interview with Culinary Manager. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the act or regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with Ontario Regulation 79/10 section 30 (1) 1, the home was to ensure that there was a hydration program that included relevant policies, and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, the home did not comply with their Hydration Assessment and Monitoring Policy, which stated that Registered Staff were to complete a dehydration assessment in the progress notes, for residents that were newly triggered for fluid watch, and as clinically indicated for any other residents on fluid watch; and to complete referrals to dietary as clinically indicated.

A: A hydration referral was completed on an identified date for a resident not meeting their daily fluid goals for three consecutive days. The referral identified that a dehydration risk assessment was to be completed by Registered Staff.

RD #119 had assessed and monitored the resident since the referral and also assessed the resident on a later date after the referral. At this time, they changed the resident's nutritional risk from moderate to high risk. A fluid assessment form identified there was no change in the resident's individualized fluid goal per day; however, monitoring for signs and symptoms of dehydration was to continue. Furthermore, the RD identified that the resident's fluid intake was to be monitored daily, and that they would follow up the following month, or sooner as needed.

The resident's fluid intake for an identified time span, indicated that the resident did not meet their fluid goal for 24 out of 29 days, and that their fluid intake was below 50% of their daily fluid goal for three consecutive days.

The resident was sent to the hospital on an identified date, and was admitted.

RD #119 identified that they assessed resident #003 monthly, at the end of the month, and that nursing was monitoring their fluid intake on a daily basis. They verified that as per the home's policy, a dehydration assessment was to be completed by nursing if the resident's fluid goal was not met. They also indicated that a referral to the dietitian would be completed as needed, including not meeting 50% of their fluid goal for three consecutive days. This would notify the dietitian to see the resident sooner. However, the last referral they received from nursing on an identified date, was not related to related to low fluid intake or a dehydration assessment.

A review of a dehydration assessment template in the progress notes, identified that the following areas were looked at in an assessment:
Fluid intake over last 72 hours; skin turgor (dry, moist, pinch test); oral mucosa (tongue dry, coated, fissured, lips dry); urine output (decreased output, urine concentrated); family notified (re: status update, fluid preferences); dietitian referral if dehydrated; doctor referral if dehydration established; and nursing interventions.

There was no dehydration assessment conducted for the resident when the initial hydration referral was completed. There was also no dehydration assessment in the month prior to their hospitalization, when they did not meet their daily fluid goals for 24 of 29 days; and was below 50% of their goal on three identified days.

Culinary Manager #117, and the DOC verified the absence of a dehydration risk assessment for the resident.

There was harm to the resident related to this non-compliance, as although their fluid intake was being monitored on a daily basis, they were not assessed for dehydration when they did not meet their daily fluid goals. The implementation of appropriate interventions including a referral to the dietitian and notification of the doctor, was not completed. The resident was sent to hospital and was admitted for treatment.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, RD #119, and DOC.

B: A hydration referral was completed for a resident on an identified date. The referral identified that the resident did not meet their daily fluid goals for three consecutive days, and a dehydration risk assessment was to be completed by registered staff.

RD #118 verified that as per the home's policy, a dehydration assessment was to be completed by Nursing if the resident's fluid goal was not met.

They also indicated that a referral to the dietitian would be completed as needed.

The resident's fluid intake for an identified time span, indicated that they did not meet their daily fluid goal in five of seven days.

A review of the resident's progress notes identified that there was no dehydration risk assessment completed for the resident when the hydration referral was completed, and the resident did not meet their fluid goal for three consecutive days. There was also no dehydration assessment completed when the resident did not meet their fluid goal for five days while on fluid watch.

There was risk to the resident related to this non-compliance as the resident was not assessed for dehydration. The resident was at risk for not having appropriate interventions in place to manage their hydration needs.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, and RD #118.

C: A hydration referral was completed for a resident on an identified date. The referral identified that the resident did not meet their daily fluid goals for three consecutive days, and a dehydration risk assessment was to be completed by registered staff.

RD #118 verified that as per the home's policy, a dehydration assessment was to be completed by Nursing if the resident's fluid goal was not met. They also indicated that a referral to the dietitian would be completed as needed.

The resident's fluid intake on an identified time span, indicated that they did not meet their daily fluid goal in five of seven days.

A review of the resident's progress notes identified that there was no dehydration risk assessment completed for the resident when the hydration referral was completed, and the resident did not meet their fluid goal for three consecutive days. There was also no dehydration assessment completed when the resident did not meet their fluid goal for five days while on fluid watch.

There was risk to the resident related to this non-compliance as the resident was not assessed for dehydration. The resident was at risk for not having appropriate interventions in place to manage their hydration needs.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, and RD #118. [s. 8. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when they had reasonable grounds to suspect the improper or incompetent treatment or care of residents had occurred that the suspicion and the information upon which it was based, was immediately reported to the Director.

A. On an identified date, the resident sustained a fall with injury, was transferred to hospital.

On an identified date, RN #126 received an allegation of improper treatment or care of the resident, related to their fall. The progress note identified that the DOC was notified of the concern.

The DOC verified that they were aware of the allegation of improper and incompetent treatment or care of the resident, and had completed an investigation of the allegation; however, they did not report it to the MLTC.

Sources: A resident's progress notes, physician's orders, and MAR, interview with DOC.

B. The home received an email related to a resident's care on an identified date. The nature of the email involved an allegation of improper treatment or care of the resident. A written response related to the complaint was provided to the complainant on an identified date, and it indicated that a copy of the complainant's letter was also sent to the

Ministry of Health and Long-Term Care.

However, there was no Critical Incident System (CIS) report found related to this incident.

Administrator #100 identified that they had forwarded a copy of their response to the MLTC as per the complaint procedure, but they did not report the incident to the MLTC when they received the letter and had grounds to suspect improper or incompetent treatment or care of the resident.

Sources: home's complaint binder, CIS reports on ltchomes.net; interview with Administrator #100.

C. The home received an email related to a resident's care on an identified date. The nature of the email involved an allegation of improper treatment or care of the resident.

The complaint log identified that a CIS was completed on an identified date, and that the incident was reported to the MLTC. However, there was no CIS report found related to the incident.

The DOC identified that the home investigated the allegation of improper care but it was not reported to the MLTC.

Sources: home's complaint binder, CIS reports on ltchomes.net; interview with DOC. [s. 24. (1)]

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 person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident's behaviours, and a resident's turning and repositioning, were documented.

A: A resident was deemed palliative on an identified date, and was ordered a certain treatment with specific indications for use.

RN #112 administered the treatment as ordered for the resident; however, there was no documentation of the indication for use of the treatment.

RN #112 identified that there was indication for use of the treatment at the time it was given.

The DOC identified that RN #112 followed the resident's plan of care related to the administration of the treatment. However, they indicated that they expected RN #112 to have documented the indications of use of the treatment in the progress notes.

Sources: A resident's progress notes, physician's order's, Medication Administration Record (MAR), interviews with RN #112, and DOC.

B: The home received an email related to a resident not being provided a certain treatment.

The DOC identified that they received the concern and that it was investigated. They identified that the resident was provided the treatment; however, the documentation for the treatment did not reflect the frequency of when the treatment was provided.

Sources: A resident's care plan, POC documentation, home's complaint binder, interview with DOC. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: 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 failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The resident's progress notes documented on an identified date, indicated that the resident had a skin impairment. It was then identified that the resident was sent to the hospital on an identified date and returned to the home after 8 days. It was identified that the skin impairment prior to hospitalization had progressed.

The home's Skin and Wound Care Policy identified that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, would have a wound progress note, weekly, if altered skin integrity was a wound, and that this would reflect the weekly assessment of the resident, related to their wound status.

The wound progress note in PCC identified areas that were a part of the wound assessment: location of the wound, stage, classification or wound type, length, width, depth, undermining or tunneling, ulcer margins, exudate, peri-wound, edema, odour, pain, cause of wound, current treatment, wound base, wound status, and referrals.

The weekly assessment of the resident's skin impairment showed that the length, depth, and width were not documented on three identified days prior to hospitalization. Additionally, after they returned from the hospital, there was an instance where the resident's skin impairment was not reassessed until 9 days after the previous assessment, in which a deterioration was identified.

The DOC identified that measurements should have been completed on the resident's assessment, and that their area of skin impairment was not reassessed within a week on an identified date.

Sources: A resident's progress notes, home's Skin and Wound Care Policy, last revised October 17, 2018; interview with DOC. [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.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee shall ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program.

An observation of the home on June 2, 2021, identified portable fans being used in the home areas on the second floor. There were two to three fans in each hallway, placed on the floor, pointing toward people passing by with some oscillating and on a high setting.

Public Health Ontario's "The Use of Portable Fans and Portable Air Conditioning Units during COVID-19 in Long-term Care and Retirement Homes" At a Glance document stated that careful consideration should be given to the use of portable fans and air conditioning units in long-term care homes or retirement homes, and that portable fans and portable air conditioning units need to be strategically located to minimize risk of potential healthcare-associated infections, as portable fans can disperse dust particles and microorganisms, and change airflow pattern. Also, portable fans could theoretically spread infectious droplets beyond two metres and contribute to COVID-19 transmission.

The home's Standard Operating Procedure for the use of fans, identified that if portable fans were used; they should be turned to low setting, and the direction of flow should be upwards toward the ceiling.

The Administrator #100 acknowledged that the home did not follow the home's IPAC program related to the use of portable fans.

Sources: observation of home areas on June 2, 2021, Public Health Ontario "The Use of Portable Fans and Portable Air Conditioning Units during COVID-19 in Long-term Care and Retirement Homes" At a Glance document, home's Standard Operating Procedure for the use of fans and air conditioning unit, version 1; interview with Administrator #100. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program required under subsection 86 (1) of the Act is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.3) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and O. Reg. 79/10, s. 20 (1.3).
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

Findings/Faits saillants :

1. The licensee failed to ensure that the heat related illness prevention and management plan for the home was implemented by the licensee every year during the period from May 15 to September 15 and also implemented, any day on which the outside temperature forecasted by Environment Canada for the area in which the home was located was 26 degrees Celsius or above at any point during the day.

On June 10, 2021, the outside temperature forecasted for the area in which the home was located was 28 degrees Celsius.

The home's heat related illness prevention and management plan identified that staff were to keep windows, shades, drapes, and blinds closed when heat alerts were in place. Additionally, they were to turn off unused equipment such as television.

On June 10, 2021, windows were observed open to the outside in three resident rooms. Television in three resident rooms were also left on, when they were not being used.

Inspector #748 showed Nurse Manager #123 the rooms identified above and they acknowledged that the outside temperature was 26 degrees or above on that day; and that the heat related illness prevention and management plan for the home should have been implemented.

Sources: Home's Prevention and Management of Hot Weather Related Illness and Conditions, last revised August 31, 2020, observation on June 10, 2021; interview with Nurse Manager #123. [s. 20. (1.3) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the home.

The temperature log for June 2021, did not identify temperatures were taken in at least two resident bedrooms in different parts of the home.

The Environmental manager identified that they completed a check on temperature for the home's main lounge and resident communal areas; in the morning and after lunch, but that temperature checks were not currently being completed in resident rooms in different parts of the home.

Sources: Temperature log June 2021; interview with Environmental Manager. [s. 21. (2) 1.]

2. The licensee failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The temperature log for June 2021, identified that temperatures were documented twice daily; once in the morning and once in the afternoon, but temperatures in the evening or night were not documented.

The Environmental manager identified that they measured temperatures in the morning and after lunch, but no one was currently assigned to measure the temperature in the evening or night.

The Acting Administrator #114 verified that the evening or night temperature measurements were not being completed or documented.

Sources: Temperature log June 2021; interview with Environmental Manager, and Acting Administrator #114. [s. 21. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident demonstrated responsive behaviours that strategies were developed and implemented to respond to the behaviours.

The resident was noted be receiving increased monitoring. On two identified dates, staff reported the resident's responsive behaviours. Their care plan did not identify strategies to respond to these behaviours.

Nurse Manager #123 identified that the resident had exhibited the behaviours reported, intermittently since admission. The written care plan was reviewed and they identified no current strategies developed and implemented to respond to the behaviours reported by staff on two identified dates.

The DOC indicated that there should have been strategies added to the care plan to address the behaviours that were reported by staff.

Sources: A resident's medical diagnosis, progress notes, and care plan; interview with Nurse Manager #123, and DOC. [s. 53. (4) (b)]

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

Issued on this 11th day of August, 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) :	EMMY HARTMANN (748)
Inspection No. / No de l’inspection :	2021_848748_0007
Log No. / No de registre :	003468-21, 005267-21, 005297-21, 005981-21, 006314-21, 009072-21, 009467-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 28, 2021
Licensee / Titulaire de permis :	859530 Ontario Inc. (operating as Jarlette Health Services) c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Royal Rose Place 635 Prince Charles Drive North, Welland, ON, L3C-0C7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Helen Millar

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 859530 Ontario Inc. (operating as Jarlette Health Services), 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must comply with section 6 (1) of the Long Term Care Homes Act (LTCHA),

Specifically, the licensee shall ensure that there are clear directions related to:
1. Resident #001's ambulation status, including the type and level of assistance they require; and
2. Any other resident's schedule of incontinent product changes.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written plan of care for residents that set out clear directions to staff and others who provided direct care to the residents.

A: A resident was deemed to be palliative on an identified date. Their progress note identified that they were not to be left unattended while in their mobility device.

On an identified date, the resident fell and sustained injuries. They were subsequently sent to hospital and diagnosed with an injury.

RN #112 identified that the resident was to remain in bed as they were palliative. Restorative Care Coordinator #113 identified that the resident was still able to use their mobility device. Nurse Manager #109 identified that the resident did not need assistance while they were in their mobility device, prior to their fall.

The resident's written care plan was reviewed and it did not include clear directions related to the resident's ambulation status, including the type of assistance they required.

Nurse Manager #109 and the DOC acknowledged the written care plan did not have clear directions to staff and others who provided direct care to resident #001.

There was a risk that the resident would not get the appropriate care related to their ambulation, due to the lack of clear directions to staff.

Sources: A resident's progress notes and care plan, interviews with RN #112, Restorative Care Coordinator, Nurse Manager #109, and DOC.

B: A resident's Continence Assessment documented on an identified date, indicated that the resident was incontinent.

Interview with PSW #122 identified that the resident was not toileted, and that they were changed according to the schedule in Point of Care (POC).

A review of resident #003's written care plan and POC tasks did not identify a schedule of when the resident's incontinent products were to be changed.

The DOC identified that the resident was changed before and after meals, and as requested; but verified that there was no schedule in the written care plan, and POC task.

There was a risk to the resident related to this non-compliance as there was no schedule of when their incontinent product was to be changed. The resident was at risk for not getting the appropriate care and assistance they needed related to continence care.

Sources: A resident's progress notes, assessments, POC task, and care plan; interview with PSW #122, and DOC. [s. 6. (1) (c)]

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

Severity: The lack of clear directions to staff, put resident #001, and #003 at risk for not getting the care that they required related to their activities of daily living.

Scope: There was a pattern of non-compliance as two of three residents were affected.

Compliance History: Four written notifications (WN), and four voluntary plans of correction (VPC), were issued to the home related to same section of the legislation in the past 36 months.

(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 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. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with section 6 (10) b. of the Long Term Care Homes Act (LTCHA),

Specifically, the licensee shall ensure that:
1. Resident #001's plan of care is revised when their care needs change related to falls risk; and
2. Any other resident's plan of care is revised when their care needs change related to dietary interventions to prevent infection.

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care were reviewed and revised when two residents' care needs changed.

A: A resident was deemed palliative on an identified date. The resident was still able to use their mobility device but a risk of falling while using their device was identified. The resident was not to be left unattended while using their mobility device.

On an identified date, the resident fell and sustained injuries.

Restorative Care Coordinator #113 identified that they witnessed the fall, and that the resident was on their own with their mobility device.

The resident's care plan identified that they were high risk for falls, but the intervention of not being left alone while using their mobility device was not included in the list of interventions.

The DOC verified that the resident's plan of care was not updated.

There was harm to the resident related to this non-compliance, as the resident was left alone while using their mobility device, when they fell and was injured as a result.

Sources: A resident's progress notes and care plan, interview with Restorative Care Coordinator #113, and DOC.

B: A resident's progress notes identified that the resident had a change in condition. The doctor was notified and a diagnostic test was ordered.

RPN #125 was noted to have spoken with the resident's substitute decision maker (SDM) on the same day and was informed by the SDM that they wanted for the resident to be an identified intervention, to manage their condition.

The resident was sent to hospital on an identified date, and was admitted.

A review of the resident's written care plan did not include the intervention to manage their condition.

Interview with the Culinary Manager identified that there was no referral completed to dietary by nursing to include the intervention to the resident's plan of care, and that it was not added in the care plan as a result.

There was risk to the resident related to this non-compliance, as the resident continued to have their condition, including being hospitalized with an infection.

Sources: A resident's progress notes and care plan, interview with Culinary Manager. [s. 6. (10) (b)]

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

Severity: The plan of care was not revised for resident #001, and resident #003, when their needs changed which put the residents at risk for not getting the care they required.

Scope: There was a pattern of non-compliance as two of three residents were affected.

Compliance History: Four written notifications (WN), and four voluntary plans of correction (VPC), were issued to the home related to same section of the legislation in the past 36 months.
(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2021

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 : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with section 8(1) of the Ontario Regulation 79/10

Specifically, the licensee shall ensure that:

1) Dehydration assessments are completed:
a. For resident #004, resident #005, and any other residents that are newly triggered for fluid watch;
b. For resident #004, and resident #005, and any other resident when they do not meet their daily fluid intake goal, while on fluid watch;

2) Dietary referrals are completed for resident #004, resident #005, and any other residents who do not meet their fluid intake goal, while on fluid watch; and

3) All registered staff are educated on the home's Hydration Assessment and Monitoring Policy, including when dehydration assessments, and dietary referrals are to be completed; how to complete the dehydration assessment; and that a record of attendance, the materials covered, and evaluation of knowledge, are documented and kept.

Grounds / Motifs :

1. The licensee failed to ensure that where the act or regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

In accordance with Ontario Regulation 79/10 section 30 (1) 1, the home was to ensure that there was a hydration program that included relevant policies, and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, the home did not comply with their Hydration Assessment and Monitoring Policy, which stated that Registered Staff were to complete a dehydration assessment in the progress notes, for residents that were newly triggered for fluid watch, and as clinically indicated for any other residents on fluid watch; and to complete referrals to dietary as clinically indicated.

A: A hydration referral was completed on an identified date for a resident not meeting their daily fluid goals for three consecutive days. The referral identified that a dehydration risk assessment was to be completed by Registered Staff.

RD #119 had assessed and monitored the resident since the referral and also assessed the resident on a later date after the referral. At this time, they changed the resident's nutritional risk from moderate to high risk. A fluid assessment form identified there was no change in the resident's individualized fluid goal per day; however, monitoring for signs and symptoms of dehydration was to continue. Furthermore, the RD identified that the resident's fluid intake was to be monitored daily, and that they would follow up the following month, or sooner as needed.

The resident's fluid intake for an identified time span, indicated that the resident did not meet their fluid goal for 24 out of 29 days, and that their fluid intake was below 50% of their daily fluid goal for three consecutive days.

The resident was sent to the hospital on an identified date, and was admitted.

RD #119 identified that they assessed resident #003 monthly, at the end of the month, and that nursing was monitoring their fluid intake on a daily basis. They verified that as per the home's policy, a dehydration assessment was to be completed by nursing if the resident's fluid goal was not met. They also indicated that a referral to the dietitian would be completed as needed, including not meeting 50% of their fluid goal for three consecutive days. This would notify

the dietitian to see the resident sooner. However, the last referral they received from nursing on an identified date, was not related to related to low fluid intake or a dehydration assessment.

A review of a dehydration assessment template in the progress notes, identified that the following areas were looked at in an assessment:
Fluid intake over last 72 hours; skin turgor (dry, moist, pinch test); oral mucosa (tongue dry, coated, fissured, lips dry); urine output (decreased output, urine concentrated); family notified (re: status update, fluid preferences); dietitian referral if dehydrated; doctor referral if dehydration established; and nursing interventions.

There was no dehydration assessment conducted for the resident when the initial hydration referral was completed. There was also no dehydration assessment in the month prior to their hospitalization, when they did not meet their daily fluid goals for 24 of 29 days; and was below 50% of their goal on three identified days.

Culinary Manager #117, and the DOC verified the absence of a dehydration risk assessment for the resident.

There was harm to the resident related to this non-compliance, as although their fluid intake was being monitored on a daily basis, they were not assessed for dehydration when they did not meet their daily fluid goals. The implementation of appropriate interventions including a referral to the dietitian and notification of the doctor, was not completed. The resident was sent to hospital and was admitted for treatment.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, RD #119, and DOC.

B: A hydration referral was completed for a resident on an identified date. The referral identified that the resident did not meet their daily fluid goals for three consecutive days, and a dehydration risk assessment was to be completed by registered staff.

RD #118 verified that as per the home's policy, a dehydration assessment was to be completed by Nursing if the resident's fluid goal was not met.

They also indicated that a referral to the dietitian would be completed as needed.

The resident's fluid intake for an identified time span, indicated that they did not meet their daily fluid goal in five of seven days.

A review of the resident's progress notes identified that there was no dehydration risk assessment completed for the resident when the hydration referral was completed, and the resident did not meet their fluid goal for three consecutive days. There was also no dehydration assessment completed when the resident did not meet their fluid goal for five days while on fluid watch.

There was risk to the resident related to this non-compliance as the resident was not assessed for dehydration. The resident was at risk for not having appropriate interventions in place to manage their hydration needs.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, and RD #118.

C: A hydration referral was completed for a resident on an identified date. The referral identified that the resident did not meet their daily fluid goals for three consecutive days, and a dehydration risk assessment was to be completed by registered staff.

RD #118 verified that as per the home's policy, a dehydration assessment was to be completed by Nursing if the resident's fluid goal was not met. They also indicated that a referral to the dietitian would be completed as needed.

The resident's fluid intake on an identified time span, indicated that they did not meet their daily fluid goal in five of seven days.

A review of the resident's progress notes identified that there was no dehydration risk assessment completed for the resident when the hydration referral was completed, and the resident did not meet their fluid goal for three consecutive days. There was also no dehydration assessment completed when the resident did not meet their fluid goal for five days while on fluid watch.

There was risk to the resident related to this non-compliance as the resident was not assessed for dehydration. The resident was at risk for not having appropriate interventions in place to manage their hydration needs.

Sources: A resident's progress notes, and PCC daily fluid intake, the home's "Hydration Assessment and Monitoring Policy", last revised August 27, 2020, dehydration assessment template in PCC, interview with Culinary Manager #117, and RD #118. [s. 8. (1)]

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

Severity: The lack of dehydration assessments and referrals to dietary when resident #003, resident #004, and resident #005 did not meet their fluid goals, placed the residents at risk by not identifying potential symptoms of dehydration. They were also at risk of not having necessary interventions implemented, to address their fluid intake and prevent dehydration.

Scope: This non-compliance was widespread as three out of three residents were affected.

Compliance History: Two written notifications (WN), and two voluntary plans of correction (VPC), were issued to the home related to same section of the legislation in the past 36 months.
(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 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:

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 28th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Emmy Hartmann

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