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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2020	2020_829757_0020	013378-20, 013387-20, 013388-20, 013389-20, 013390-20, 013391-20	Follow up

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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

DAVID SCHAEFER (757), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24-28, 2020.

The following intakes were inspected in this follow up inspection:
-a follow up intake for Compliance Order (CO) #007 issued during inspection #2020_829757_0008 under s. 19 (1) of the Long-Term Care Homes Act (LTCHA), related to abuse and neglect of residents;
-a follow up intake for CO #008 issued during inspection #2020_829757_0008 under s. 101 of Ontario Regulation (O. Reg.) 79/10, related to the home's complaints process;
-a follow up intake for CO #004 issued during inspection #2020_829757_0008 under s. 87 (2) of O. Reg. 79/10, related to the cleaning and disinfecting of resident care equipment;
-a follow up intake for CO #003 issued during inspection #2020_829757_0008 under s. 33 (1) of O. Reg. 79/10, related to twice weekly bathing of residents;
-a follow up intake for CO #001 issued during inspection #2020_829757_0008 under s. 6 (7) of the LTCHA, related to the provision of care per resident care plans; and
-a follow up intake for CO #001 issued during inspection #2020_829757_0007 under s. 104 (1) of O. Reg. 79/10, related to the reporting of alleged, suspected, or witnessed incidents of abuse and neglect.

This inspection was conducted concurrently with critical incident system inspection #2020_829757_0019.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Office Manager, Registered Practical Nurse (RPN), and a Personal Support Worker (PSW).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Personal Support Services
Reporting and Complaints

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101.	CO #008	2020_829757_0008	757
O.Reg 79/10 s. 104. (1)	CO #001	2020_829757_0007	757
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #007	2020_829757_0008	757
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_829757_0008	621
O.Reg 79/10 s. 87. (2)	CO #004	2020_829757_0008	757

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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a

minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition.

Compliance Order (CO) #003 was issued to the home on July 3, 2020, in inspection report #2020_829757_0008, with a compliance due date of August 5, 2020. The order specified:
"The licensee must comply with s. 33 (1) of Ontario Regulation 79/10.
Specifically, the licensee must:
a) Ensure that residents #001, #004, #011, #014, #015, and all other residents are bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition.
b) Develop a documented auditing system to track which residents have not received a bath on their scheduled days, communicate this with direct care staff, and follow-up to ensure bathing requirements are met."

Inspector #757 reviewed the home's documented auditing system for bathing, which was required under CO #003. The inspector identified five residents who had not received twice weekly baths.

The home's policy "Bathing, Showering and Water Temperature Monitoring - RC-06-01-02", last updated June 2020, under the heading of "care staff" stated "refused bathing will be documented on the daily care record (or electronic equivalent) as well as alternate interventions utilized to promote the resident's comfort and hygiene". The policy stated that for the purposes of the policy, "bathing" included tub baths, showers and full body sponge baths.

A) The inspector reviewed the electronic Point of Care (POC) documentation for resident #008 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered seven baths, and had refused seven times. Resident #008 received zero baths between these dates. The documentation also indicated that no baths had been offered to resident #008 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

Resident #008's current care plan indicated that the resident required one person assistance for bathing.

During an interview with PSW #102, they stated that the resident was difficult to bathe, indicating that the resident had behaviours. They added that it was not acceptable that resident #008 had not yet received a bath during August.

During an interview with the home's Acting Director of Care (DOC), they stated they were not aware of the resident's trend of missed baths, or that they had gone so long without a bath.

B) The inspector reviewed the electronic POC documentation for resident #014 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered six baths, but had refused five times. The resident received one bath between these dates. The documentation also indicated that no baths had been offered to resident #014 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

Resident #014's current care plan, stated that the resident required supervision or assistance for bathing. The resident's care plan also indicated strategies for staff to utilize to encourage bathing.

During an interview with PSW #102, they stated that this resident had not received an appropriate frequency of bathing.

C) Resident #015's current care plan stated that the resident required assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #015 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered five baths, and refused four times. Resident #015 received one bath between these dates. The documentation also indicated that no baths had been offered to resident #015 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

D) Resident #012's current care plan stated that the resident required one person assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #012 from August

5, 2020, to the time of inspection, related to bathing and identified that:
-The resident was offered six baths and refused three times; and
-No bath was offered on August 26 (the resident had gone eight days without a bath at that time).

Resident #012 did not receive twice weekly baths. The documentation also indicated that no baths had been offered to resident #012 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

E) Resident #013's current care plan stated that the resident required one person assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #013 from August 5, 2020, to the time of inspection related to bathing and identified that:
-The resident was offered five baths and refused three times; and
-No bath was offered on one of the scheduled bath days.

During an interview with PSW #102, they stated that resident #013 would sometimes decline a bath one day, but then would accept having a bath the following day.

Resident #013 received two baths from August 5, 2020 to the time of inspection, and did not receive the required twice weekly baths. The resident's POC documentation indicated that no baths had been offered to resident #013 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

During an interview conducted with PSW #102 they stated that when a resident refused a bath, they would reapproach the resident three times during the shift, in addition to asking the registered staff to attempt. They added that if the resident still refused after three attempts, they would inform the charge nurse, who would then ask the following shift or day to complete the bath. The PSW stated that they received an electronic alert on their POC system to indicate that a resident they were caring for had previously missed a bath.

Inspector #757 conducted an interview with RPN #103 who stated that they were aware of the legislative requirement for residents to receive baths twice weekly. The RPN stated that baths that were missed due to staffing would be endorsed to the next shift, but baths

that were missed due to a refusal would not be. When asked how the home would be able to ensure that a resident who had refused their bath received the required twice weekly baths, they indicated that they would not be able to ensure this.

Inspector #757 conducted an interview with the Acting DOC, who confirmed that residents #008, #012, #013, #014, and #015, had not received twice weekly baths. They stated that when a resident refused a bath, staff were to re-offer the bath up to three times and document the result. They stated that some of the residents in the home were very difficult to bathe, so some residents required an alternate approach. The Acting DOC added that when an alternate approach was used, this would be documented in the resident's progress notes. The Acting DOC stated that missed or refused baths should have been endorsed to the following shift or day in order to meet the requirement for twice weekly bathing. They stated that hey had not contacted the residents' power of attorneys to inform them of the lack of bathing, or to discuss strategies for bathing. They stated that residents who had received one or zero baths in August 2020 did not receive an acceptable level of hygiene.

Inspector #757 conducted a review of progress notes for residents #008, #012, #013, #014, and #015, between the dates of August 5 to August 26, 2020. None of the resident's progress notes included any indication that any alternate interventions had been utilized to promote the resident's comfort and hygiene, per the home's policy.

During an interview with the home's Executive Director (ED) they stated that the home had their own interpretation of what a shower or bath was, and that they provided personal grooming and peri-care to these residents. Section 33 (2) of Ontario Regulation (O. Reg.) 79/10, states that bathing includes "tub baths, showers, and full body sponge baths". The ED stated that the requirement of CO #003 for all residents to be bathed at minimum twice weekly, was not met. [s. 33. (1)]

Additional Required Actions:

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 10th day of September, 2020

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), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2020_829757_0020
Log No. / No de registre :	013378-20, 013387-20, 013388-20, 013389-20, 013390-20, 013391-20
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 9, 2020
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

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 CVH (No. 2) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2020_829757_0008, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

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 be compliant with s. 33 (1) of Ontario Regulation 79/10.

Specifically, the licensee must:

a) Ensure that residents #008, #012, #013, #014, and #015 are bathed, at a minimum, twice a week by the method of his or her choice, or more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

b) Revise the home's current bathing auditing system to include tracking of how many days have accrued since the resident's previous bath in order to identify gaps in bathing care.

c) Ensure that where a resident has missed a bath, through refusal or otherwise, the home will follow-up to ensure that these baths are endorsed to the next day or shift. This follow-up and the resident's response must be documented.

d) Ensure that where a resident develops a pattern of persistent bathing refusals, the home will engage in interdisciplinary care meetings and make referrals to appropriate services, as required, to develop, document, and implement alternate strategies for bathing. The meetings must be documented and must discuss, at a minimum, resident behaviours and challenges related to bathing, as well as the strategies developed to address these. The home must also engage in discussion with the resident's substitute decision maker (SDM), if applicable, to discuss bathing issues and possible strategies for bathing.

e) Ensure that where strategies for dealing with bathing refusals have been implemented, they are assessed for effectiveness after two weeks. If strategies have still not been effective in meeting the twice weekly bathing requirement, alternate strategies must be pursued.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Compliance Order (CO) #003 was issued to the home on July 3, 2020, in inspection report #2020_829757_0008, with a compliance due date of August 5, 2020. The order specified:
"The licensee must comply with s. 33 (1) of Ontario Regulation 79/10. Specifically, the licensee must:
a) Ensure that residents #001, #004, #011, #014, #015, and all other residents are bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
b) Develop a documented auditing system to track which residents have not received a bath on their scheduled days, communicate this with direct care staff, and follow-up to ensure bathing requirements are met."

Inspector #757 reviewed the home's documented auditing system for bathing, which was required under CO #003. The inspector identified five residents who had not received twice weekly baths.

The home's policy "Bathing, Showering and Water Temperature Monitoring - RC-06-01-02", last updated June 2020, under the heading of "care staff" stated "refused bathing will be documented on the daily care record (or electronic equivalent) as well as alternate interventions utilized to promote the resident's comfort and hygiene". The policy stated that for the purposes of the policy, "bathing" included tub baths, showers and full body sponge baths.

A) The inspector reviewed the electronic Point of Care (POC) documentation for resident #008 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered seven baths, and had refused seven times. Resident #008 received zero baths between these dates. The documentation also indicated that no baths had been offered to resident #008 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

Resident #008's current care plan indicated that the resident required one person assistance for bathing.

During an interview with PSW #102, they stated that the resident was difficult to bathe, indicating that the resident had behaviours. They added that it was not

acceptable that resident #008 had not yet received a bath during August.

During an interview with the home's Acting Director of Care (DOC), they stated they were not aware of the resident's trend of missed baths, or that they had gone so long without a bath.

B) The inspector reviewed the electronic POC documentation for resident #014 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered six baths, but had refused five times. The resident received one bath between these dates. The documentation also indicated that no baths had been offered to resident #014 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

Resident #014's current care plan, stated that the resident required supervision or assistance for bathing. The resident's care plan also indicated strategies for staff to utilize to encourage bathing.

During an interview with PSW #102, they stated that this resident had not received an appropriate frequency of bathing.

C) Resident #015's current care plan stated that the resident required assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #015 from August 5, 2020, to the time of inspection related to bathing and identified that the resident had been offered five baths, and refused four times. Resident #015 received one bath between these dates. The documentation also indicated that no baths had been offered to resident #015 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

D) Resident #012's current care plan stated that the resident required one person assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #012 from August 5, 2020, to the time of inspection, related to bathing and identified

that:
-The resident was offered six baths and refused three times; and
-No bath was offered on August 26 (the resident had gone eight days without a bath at that time).

Resident #012 did not receive twice weekly baths. The documentation also indicated that no baths had been offered to resident #012 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

E) Resident #013's current care plan stated that the resident required one person assistance for bathing.

The inspector reviewed the electronic POC documentation for resident #013 from August 5, 2020, to the time of inspection related to bathing and identified that:
-The resident was offered five baths and refused three times; and
-No bath was offered on one of the scheduled bath days.

During an interview with PSW #102, they stated that resident #013 would sometimes decline a bath one day, but then would accept having a bath the following day.

Resident #013 received two baths from August 5, 2020 to the time of inspection, and did not receive the required twice weekly baths. The resident's POC documentation indicated that no baths had been offered to resident #013 on any subsequent day or shift between the resident's scheduled bath days following a refusal, in order to meet the requirement for twice weekly bathing.

During an interview conducted with PSW #102 they stated that when a resident refused a bath, they would reapproach the resident three times during the shift, in addition to asking the registered staff to attempt. They added that if the resident still refused after three attempts, they would inform the charge nurse, who would then ask the following shift or day to complete the bath. The PSW stated that they received an electronic alert on their POC system to indicate that a resident they were caring for had previously missed a bath.

Inspector #757 conducted an interview with RPN #103 who stated that they were aware of the legislative requirement for residents to receive baths twice weekly. The RPN stated that baths that were missed due to staffing would be endorsed to the next shift, but baths that were missed due to a refusal would not be. When asked how the home would be able to ensure that a resident who had refused their bath received the required twice weekly baths, they indicated that they would not be able to ensure this.

Inspector #757 conducted an interview with the Acting DOC, who confirmed that residents #008, #012, #013, #014, and #015, had not received twice weekly baths. They stated that when a resident refused a bath, staff were to re-offer the bath up to three times and document the result. They stated that some of the residents in the home were very difficult to bathe, so some residents required an alternate approach. The Acting DOC added that when an alternate approach was used, this would be documented in the resident's progress notes. The Acting DOC stated that missed or refused baths should have been endorsed to the following shift or day in order to meet the requirement for twice weekly bathing. They stated that hey had not contacted the residents' power of attorneys to inform them of the lack of bathing, or to discuss strategies for bathing. They stated that residents who had received one or zero baths in August 2020 did not receive an acceptable level of hygiene.

Inspector #757 conducted a review of progress notes for residents #008, #012, #013, #014, and #015, between the dates of August 5 to August 26, 2020. None of the resident's progress notes included any indication that any alternate interventions had been utilized to promote the resident's comfort and hygiene, per the home's policy.

During an interview with the home's Executive Director (ED) they stated that the home had their own interpretation of what a shower or bath was, and that they provided personal grooming and peri-care to these residents. Section 33 (2) of Ontario Regulation (O. Reg.) 79/10, states that bathing includes "tub baths, showers, and full body sponge baths". The ED stated that the requirement of CO #003 for all residents to be bathed at minimum twice weekly, was not met. [s. 33. (1)]

The decision to issue a Compliance Order (CO) was based on the severity of the

issue, which was a level 3, indicating risk of harm to residents. The scope of the issue was a level 2, indicating a pattern. The home's compliance history related to the issue was a level 4, indicating a re-issued compliance order to the same subsection and three or fewer COs:
- CO issued June 23, 2020, in inspection report #2020_829757_0008, with a compliance due date of August 5, 2020.
- VPC issued June 1, 2018, in inspection report #2018_624196_0011. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 08, 2020

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 9th day of September, 2020

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