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
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 03, 2020	2020_829757_0019 (A1)	012201-20, 013000-20, 014167-20	Critical Incident System

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

Amended by DAVID SCHAEFER (757) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This licensee inspection report has been revised to reflect an updated compliance due date for compliance order #002 to determine current compliance. The Critical Incident System inspection, #2020_829757_0019 was completed on August 24-28.
A copy of the revised report is attached.

Issued on this 3 rd day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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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
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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

Amended by DAVID SCHAEFER (757) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

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

The following intakes were inspected during this Critical Incident System inspection:

-Two intakes related to resident-to-resident physical altercations; and

-One intake related to the unexpected death of a resident.

This inspection was conducted concurrently with follow up inspection #2020_829757_0020.

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, Nutrition Manager, Behavioural Supports Ontario (BSO) Supervisor, Geriatric Mental Health Worker, Nurse Practitioner (NP), Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Worker (PSWs), Dietary Aide, and a Cook.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Responsive Behaviours

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

4 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that for each resident who demonstrated responsive behaviours, the behavioural triggers for the resident were identified, where possible.

a) A Critical Incident System (CIS) report was received by the Director concerning resident-to-resident responsive behaviours. The report indicated that resident #008 and #007 were in a physical altercation, where resident #008 was the aggressor. The altercation resulted in both residents pushing each other, and one resident incurred an injury as a result.

A review of the home's program, "Responsive Behaviours - RC-17-01-04", revised December 2019, indicated that staff were to ensure that that resident care plans included a description of their behaviours and triggers for their behaviours.

A review of resident #008's health care record revealed that resident #008 had six incidents of verbal and/or physical aggression towards other residents from January 2020, to present.

A review of resident #008's current care plan described their behaviour as verbally and physically aggressive. Behavioural triggers were not identified in the care plan.

A review of a 'Psychogeriatric Resource Consultant Report' for resident #008 advised that by completing a Dementia Observational System (DOS) document, the home could identify patterns or triggers for their responsive behaviours.

During an interview with Registered Practical Nurse (RPN) #114, they identified a number of behavioural triggers for resident #008. Together with Inspector #577, they reviewed resident #008's care plan, confirmed that the care plan had not identified any triggers, and indicated that they should have been identified.

During an interview with the Executive Director (ED) and the Acting Director of Care (DOC), they advised that behavioural triggers needed to be identified in residents' care plans. During a review of resident #008's care plan, they confirmed that behavioural triggers had not been identified.

b) A CIS report was received by the Director concerning resident-to-resident responsive behaviours. The report indicated that resident #009 was the aggressor in a physical altercation with residents #010 and #011. The report indicated that two residents fell and one incurred an injury as a result of the altercation.

A review of resident #009's health care record revealed that there had been a prior altercation with a co-resident where they had hit the co-resident.

A review of resident #009's current care plan identified the resident's responsive behaviours. The care plan did not identify behavioural triggers.

During an interview with RPN #114, they indicated resident #009's behaviours. Together with Inspector #577, they reviewed resident #009's care plan, confirmed that the care plan had not identified any triggers, and indicated that they should have been identified.

During an interview with the ED and the Acting DOC, they advised that behavioural triggers needed to be identified in residents' care plans. During a review of resident #009's care plan, they confirmed that behavioural triggers had not been identified. [s. 53. (4) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A CIS report was submitted to the Director related to the unexpected death of resident #006.

During an interview with the home's Nutrition Manager (NM), and on inquiry as to the contact information for the home's Registered Dietitian (RD), Inspector #621 was informed that the home had been without the services of an on-site RD since March 2020.

During an interview with the ED, they reported to the Inspector that the home had been without the services of an on-site RD since March 2020. They reported that recruitment efforts had been ongoing, but unsuccessful, and that the home's NM, the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner who had been working remotely, and registered nursing staff had been assisting with the completion of elements of the RD's duties and responsibilities. The ED provided bed census reports for the home from April to August 2020, and reported that the home normally had a bed census of 96, but with social distancing restrictions on ward rooms during the pandemic, the bed census had been reduced to 79 beds since June 2020.

The following calculation was used by the Inspector to determine the RD's required hours in the home:
- Resident census for the home for April and May 2020 = 96 residents x 30 minutes per month = 2880 minutes or 48 hours per month; and
- Resident census for the home for June, July, and August, 2020 = 79 residents x 30 minutes per month = 2379 minutes or 39.5 hours per month.

On subsequent interview, the ED confirmed that at the time of inspection, the home had been without an RD since March 2020, and had been unable to fulfill its legislative requirements to provide a minimum of 30 minutes per resident per month of on-site RD time to support clinical and nutrition care duties. [s. 74. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was approved by a registered dietitian who was a member of the staff of the home.

A CIS report was submitted to the Director related to the unexpected death of resident #006.

During an interview with the home's Nutrition Manager (NM), and on inquiry as to the contact information for the home's Registered Dietitian (RD), Inspector #621 was informed that the home had been without the services of an on-site RD since March 2020. The NM informed the Inspector that the Spring/Summer 2020 planned menu had been implemented in the home on May 20, 2020, and confirmed that in the absence of an on-site RD during this time, RD approval of the Spring/Summer 2020 planned menu as per legislative requirements, did not occur.

During an interview with Office Manager #107 (who was the former NM of the home), they identified to the Inspector that prior to their move into the role of Office Manager in the home on November 18, 2019, they had ensured as the NM, that the home's RD completed a review and approved of the home's seasonal planned menu before implementation. They identified that there was a form that the on-site RD completed, that they were required to keep on file to support this requirement.

During an interview with the home's ED, they reported that the last day the home had on-site RD services was March 27, 2020. [s. 71. (1) (e)]

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 home's menu cycle is approved by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person hired as a nutrition manager was an active member of the Canadian Society of Nutrition Management or a registered dietitian.

A CIS report was submitted to the Director related to the unexpected death of resident #006.

During an interview with the home's Office Manager #107, it was reported to the Inspector that the home had hired into the role of Nutrition Manager (NM), a cook who had their culinary certificate, but was not an active member of the Canadian Society of Nutrition Management (CSNM). They identified that the former cook was hired into the role on an interim basis in November 2019, and had remained in the role since that time.

During an interview with NM #106, they informed the Inspector that they had accepted the position of NM with the home back in November 2019, but were resigning. When the Inspector inquired as to their qualifications, they reported that they had been taking course work to qualify for writing of the CSNM exam to become an active member, but at the time of inspection, had not yet completed this course work, and were not an active member of the CSNM, as per legislative requirements. They also confirmed that they were not a registered dietitian.

During an interview with the ED, they informed Inspector #621 that at the time of inspection, the home's NM had accepted the role of NM on an interim basis as of November 18, 2019. Then on January 20, 2020, they offered the NM a permanent position in the same role, with condition that they complete the necessary education/training to become an active member of the CSNM. The ED reported that at the time of inspection, this course work had not yet been completed. The ED also identified that NM #106 had taken leave for a month prior to their return over the previous week, and on their return had submitted their resignation. The ED confirmed to the Inspector that from November 18, 2019, up until the time of inspection, the home had been operating with an employee in the role of Nutrition Manager, who did not possess active membership with the CSNM, as per legislative requirements. [s. 75. (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 a person hired as a nutrition manager is an active member of the Canadian Society of Nutrition Management or a registered dietitian, to be implemented voluntarily.

Issued on this 3 rd day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DAVID SCHAEFER (757) - (A1)
Inspection No. / No de l'inspection :	2020_829757_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012201-20, 013000-20, 014167-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 03, 2020(A1)
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:

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 :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must comply with s. 53 (4) of Ontario Regulation (O. Reg.) 79/10.

Specifically the licensee must ensure that behavioural triggers are identified in the care plans for residents #008 and #009.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours, the behavioural triggers for the resident were identified, where possible.

a) A Critical Incident System (CIS) report was received by the Director concerning resident-to-resident responsive behaviours. The report indicated that resident #008 and #007 were in a physical altercation, where resident #008 was the aggressor. The altercation resulted in both residents pushing each other, and one resident incurred an injury as a result.

A review of the home's program, "Responsive Behaviours - RC-17-01-04", revised December 2019, indicated that staff were to ensure that that resident care plans included a description of their behaviours and triggers for their behaviours.

A review of resident #008's health care record revealed that resident #008 had six incidents of verbal and/or physical aggression towards other residents from January 2020, to present.

A review of resident #008's current care plan described their behaviour as verbally and physically aggressive. Behavioural triggers were not identified in the care plan.

A review of a 'Psychogeriatric Resource Consultant Report' for resident #008 advised that by completing a Dementia Observational System (DOS) document, the home could identify patterns or triggers for their responsive behaviours.

During an interview with Registered Practical Nurse (RPN) #114, they identified a number of behavioural triggers for resident #008. Together with Inspector #577, they reviewed resident #008's care plan, confirmed that the care plan had not identified any triggers, and indicated that they should have been identified.

During an interview with the Executive Director (ED) and the Acting Director of Care (DOC), they advised that behavioural triggers needed to be identified in residents' care plans. During a review of resident #008's care plan, they confirmed that behavioural triggers had not been identified.

b) A CIS report was received by the Director concerning resident-to-resident responsive behaviours. The report indicated that resident #009 was the aggressor in a physical altercation with residents #010 and #011. The report indicated that two residents fell and one incurred an injury as a result of the altercation.

A review of resident #009's health care record revealed that there had been a prior altercation with a co-resident where they had hit the co-resident.

A review of resident #009's current care plan identified the resident's responsive behaviours. The care plan did not identify behavioural triggers.

During an interview with RPN #114, they indicated resident #009's behaviours. Together with Inspector #577, they reviewed resident #009's care plan, confirmed that the care plan had not identified any triggers, and indicated that they should have been identified.

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

During an interview with the ED and the Acting DOC, they advised that behavioural triggers needed to be identified in residents' care plans. During a review of resident #009’s care plan, they confirmed that behavioural triggers had not been identified. [s. 53. (4) (a)]

The decision to issue a Compliance Order (CO) was based on the severity of the issue, which was a level 3, indicating actual resident harm. The scope of the issue was a level 2, indicating a pattern. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- VPC issued December 9, 2019, in inspection report #2019_633577_0033; and
- CO issued May 13, 2019, in inspection report #2019_624196_0010, and complied June 22, 2019. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 18, 2020

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 :

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The licensee must comply with s. 74 (2) of O. Reg. 79/10.

Specifically, the licensee must ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A CIS report was submitted to the Director related to the unexpected death of resident #006.

During an interview with the home's Nutrition Manager (NM), and on inquiry as to the contact information for the home's Registered Dietitian (RD), Inspector #621 was informed that the home had been without the services of an on-site RD since March 2020.

During an interview with the ED, they reported to the Inspector that the home had been without the services of an on-site RD since March 2020. They reported that recruitment efforts had been ongoing, but unsuccessful, and that the home's NM, the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner who had been working remotely, and registered nursing staff had been assisting with the

completion of elements of the RD's duties and responsibilities. The ED provided bed census reports for the home from April to August 2020, and reported that the home normally had a bed census of 96, but with social distancing restrictions on ward rooms during the pandemic, the bed census had been reduced to 79 beds since June 2020.

The following calculation was used by the Inspector to determine the RD's required hours in the home:
- Resident census for the home for April and May 2020 = 96 residents x 30 minutes per month = 2880 minutes or 48 hours per month; and
- Resident census for the home for June, July, and August, 2020 = 79 residents x 30 minutes per month = 2379 minutes or 39.5 hours per month.

On subsequent interview, the ED confirmed that at the time of inspection, the home had been without an RD since March 2020, and had been unable to fulfill its legislative requirements to provide a minimum of 30 minutes per resident per month of on-site RD time to support clinical and nutrition care duties. [s. 74. (2)]

The decision to issue a CO was based on the scope of the issue which was a level 3, indicating that the issue was widespread. The severity of the issue was a level 2, indicating a risk of harm. The home's compliance history related to this issue was a level 2, indicating no history of non-compliance related to this subsection. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 3 rd day of November, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by DAVID SCHAEFER (757) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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