Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2019	2019_539120_0020 (A2)	002461-19, 002471-19, 002472-19, 002473-19, 002474-19	Follow up

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The public report was amended to remove personal health information.

Issued on this 30th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended 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): May 21, 23, 27, 29 (on site), June 12, 14, 18, 24, 2019 (off site)

A Resident Quality Inspection (2018-756583-0014) was previously conducted from September to November 2018, at which time non-compliance was identified with multiple areas under the Long Term Care Homes Act and Regulation. This follow up inspection was conducted in relation specifically to compliance orders #001 to #005, related to the licensee's infection prevention and control program and specific safety related issues. Although the compliance orders were cleared, some non-compliance was identified during the inspection and addressed below.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Quality Improvement Co-ordinator, Nutrition/Housekeeping Manager, maintenance staff, personal support workers and housekeepers.

During the course of the inspection, the inspector toured the building, including staff spaces, common areas, resident rooms, bathing rooms and outdoor spaces. Documentation, policies and procedures and/or service reports related to maintenance services, infection prevention and control, housekeeping and safety were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
5 WN(s)
5 VPC(s)
0 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. 229. (10)	CO #002	2018_756583_0014	120
O.Reg 79/10 s. 229. (10)	CO #003	2018_756583_0014	120
O.Reg 79/10 s. 229. (6)	CO #004	2018_756583_0014	120
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2018_756583_0014	120
LTCHA, 2007 S.O. 2007, c.8 s. 86. (2)	CO #005	2018_756583_0014	120

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

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe environment for its residents.

On the third day of inspection, the enclosed outdoor courtyard for resident use was not secured. A gate was left closed but was not secured. A chain with a pad lock was attached to the gate but was not wrapped around the gate and gate post to keep the gate secured. According to the maintenance person, a lawn care contractor used the gate to gain access to the grass areas for mowing. Discussion held regarding regular monitoring of the gate and ensuring that the

lawn care contractor is aware of the requirement for a secure outdoor courtyard.

On the third day of inspection, an exit door leading to the side of the home was left unlocked from the outside. The door led directly into a stairwell and into resident areas on both first and second floors. The door was left unlocked to accommodate staff who were using the door to gain access to an outdoor rest area. The door was not equipped with any form of access control other than a key lock. According to the maintenance person, staff did not carry a key for the door. The administrator reported that it was locked by end of the day.

On the first day of inspection, the second floor lounge included one large window that opened greater than 15 cm, allowing easy access for resident egress. The issue was reported to the maintenance person immediately and the window was restricted.

On the second day of inspection, a slide bolt lock was noted on a palliative resident room door, on the outside (hall side) of the door. The lock, when engaged could cause someone to become confined in the room. The administrator identified that the lock was used to keep residents out of the washroom located within the room. Alternatives were suggested at the time of the inspection, that did not include concerns related to accidental confinement.

On the last day of inspection, the over bed lights in many resident rooms were observed to be used a storage shelf. Heavy picture frames and other items were noted on the lights. The light fixtures were not designed to hold additional weight or to have any circulation along the top blocked. On the same date, many resident washrooms were observed to have multiple heavy glass vases stored on top of their personal grooming supply cabinets. The cabinets were narrow, only 3 -4 inches deep and not ideal for the placement of breakable objects. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

(A2)
1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that,was available at each bed location used by residents.

On the second day of inspection, an identified resident room was observed to have two beds located on one wall, side by side, instead of across from each other. An activation station was located on each wall. However, when the beds were re-located, only one resident had access to their activation station. The matter was raised with the maintenance person and the Director of Care, who were both unaware of the situation and made arrangements to order a split cable that had a call button on each end.

On the third day of inspection, another resident room was also identified to be arranged in the same way and one resident was without access to an activation station. [s. 17. (1) (d)]

2. The licensee failed to ensure that the resident-staff communication and response system (RSCRS) was properly calibrated so that the level of sound was audible to staff.

During tours of the first and second floor, a portion of the audible component of the RSCRS on both floors was muffled by the sound of large wall mounted fans throughout the corridors. A small speaker was located near the end of each corridor, near the ceiling, which produced a slight "beep beep" sound when an activation station was triggered by a user. At the same time, a sound was produced at the nurse's station that was much louder. The sound at the nurse's station could be heard clearly until the second resident room. Beyond that, the sound was drowned out by the portable wall fans. The sound emanating from the smaller speakers in the corridors could not be heard beyond the first two resident rooms on either side of the speakers. When in the resident rooms, no component of the RSCRS could be heard unless right next to the nurse's stations.

A resident in an identified room activated their activation station, but it could not be heard while touring the corridors until the nurse's station was approached. Four staff members were in the dining room near the nurses' station, and no staff members responded to the call after 10 minutes. The inspector went to the resident's room to determine if the resident required assistance.

The requirements for the audible component of the system to be calibrated so that it could be heard equally throughout the floor area was discussed with the Administrator. [s. 17. (1) (g)]

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 resident-staff communication and response system is available at each bed location used by residents and that the level of sound is properly calibrated to that the level of sound is audible to staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

On the first day of inspection, many staff members reported that offensive lingering odours were generated in two different areas of the home and had not been resolved for many months. The first area included a room used by residents. The odours were reported to be strong first thing in the morning and once staff opened a window in the room, and ran the water in a specified fixture, the odours would subside, but a musty smell would continue to linger.

During the inspection, over the course of several days, the musty smell was verified and linked to wet soil that was exposed around a a drainage pipe in the floor behind a specified fixture. Staff reported that water occasionally spilled onto the floor and drained into the soil. Staff reported that the musty smell was the least offensive, that another type of odour was more prevalent upon entry in the morning.

The maintenance person was aware of the issue but had not attempted to resolve the problem prior to the inspection. During the inspection, the maintenance

person attempted to resolve the issue, but was not successful. The maintenance person was informed that the services of a certified plumber would be necessary.

The second area included a staff area located in a basement, which included a lunch room and men and ladies washrooms. Odours were reported to maintenance personnel many times by staff. The staff reported not being able to eat their lunch in the area due to the foul odours which related to sewage or sewer gas. Multiple staff reported that the odours would come and go and that the odours have been present for numerous years. According to the maintenance person, a number of products were poured down into the drains, but without effect. During the inspection, the drain in the ladies washroom smelled foul. It was confirmed by the maintenance person that a septic pit with pumps was located under the floor in the men's washroom. The waste water and sewage emptied into the pit and would be pumped out to the street level to a municipal sanitary sewer. Post inspection, toilet seals were replaced and a seal for the septic pit was ordered.

The administrator provided their maintenance and housekeeping policies and procedures for review, and no procedures were included related to the management and resolution of various types of offensive lingering odours that could be generated within the home. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were procedures in place for preventive maintenance.

The licensee's preventive maintenance program required that the maintenance person conduct a monthly inspection of all furnishings and surfaces in each resident room on a monthly basis and to use the " Maintenance General Inspection Checklist (MDM-III-20). The results were to be provided to the Administrator, who was also the Maintenance Manager for follow up action, if any were necessary.

The Administrator was not aware of any of the audit results when asked on the last day of inspection. They were later forwarded by email to the inspector on the same day. The results included an audit of resident rooms on the first floor in January 2019, and the second floor in February 2019. When the administrator was asked for results for 2018, none could be provided. A review of the maintenance policies and procedures revealed missing procedures related to furnishings (beds, night tables, wardrobes, tables, chairs) and current procedures for tub maintenance.

The inspection checklist included a list of each room and what was checked. Both the exhaust fan and "furnishings" were listed. For each of the resident rooms identified above that were observed to be in disrepair or not functioning adequately, the inspection checklist results identified that the exhaust fans and furnishings were in good condition.

During a tour of the home during the last two days of inspection, the exhaust fans in resident washrooms and both resident tub rooms did not appear to be functioning well and were very dusty.

An identified tub room ceiling exhaust unit had limited suction (as tested with a tissue) and the room was very stuffy. A secondary exhaust system located above and behind the toilets in each of the two tub room were believed to have been installed to enhance removal of moist air and odours from the tub rooms, however they were not functional. The maintenance person reported that a contractor was hired to replace the secondary exhaust system with a new unit. No specific date of installation could be provided, but it was anticipated that the units would be installed by the end of June 2019.

The exhaust fans in nine identified resident washrooms were noisy and not like many of the other fans that appeared to be working well. The maintenance person reported that the exhaust fans were last checked by himself approximately eight months earlier, but no records could be provided for review from that time period. They stated that they relied on other staff to bring disrepair to their attention. During the inspection, the Administrator and maintenance person developed a checklist for each exhaust fan to be cleaned of dust and checked for proper function. The work was to be undertaken by the maintenance person over the course of the summer.

Night tables in five identified resident rooms were not in good condition. The press board was exposed along the edges of the tables and were rough and could no longer be cleaned. The Administrator was informed about the condition of the night tables but was not aware of their condition.

The preventive maintenance program was not fully developed and in place at the time of inspection. [s. 90. (1) (b)]

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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there are procedures in place for preventive maintenance, to be implemented voluntarily.

WN #5: 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 :

(A2)
1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

As per s.86(2)(b) of the Long Term Care Homes Act, the infection prevention and control program must include measures to prevent the transmission of infections, which includes but is not limited to cleaning and disinfection practices and how personal items are stored and handled.

During the inspection, two tub rooms were observed to have various personal hygiene products such as deodorant, combs, brushes and nail clippers sitting loosely on various surfaces.

In one of the tub rooms, three different roll on deodorants without a label were observed on top of the towel warmer unit. None of them were labelled as belonging to any particular resident. Verification as to whether they were used on various residents was not made.

A large rusty nail clipper was left on top of the towel warmer unit and many small clippers were observed inside a plastic container. Staff member #008 was asked to describe how the clippers were handled and they reported that once the clippers were used, they were placed directly into the hand sink and sprayed (not soaked or submerged) with a disinfectant. Once removed from the sink, they

were placed on top of the towel warmer unit. The cleaned nail clippers were not stored in a designated clean container or compartment. There was no method in which to determine when a nail clipper was dirty and waiting to be disinfected or was already disinfected.

In another tub room, a large toe nail clipper (shaped like pliers) was stored on top of a calculator, next to a loose toothbrush, masking tape, hand sanitizer gel and other loose items on a shelf under the towel warming unit and an unlabelled used hairbrush and roll on deodorant were stored in a basket on the same shelf. On top of the towel warmer unit were five black combs, disposable razor and a large nail clipper.

On the third day of inspection, one of the tub rooms had three loose large nail clippers sitting on various surfaces and the second floor tub room had an electric shaver and unlabelled hair brush sitting loosely with masking tape, a calculator, and other objects on a shelf under the towel warming unit.

Shared resident washrooms were randomly toured for personal items that were missing a label or not stored appropriately. In one identified washroom, an unlabelled soiled urine measure hat was observed on a grab bar, and several unlabelled used hair brushes. In three other identified washrooms, a urine measure was observed on the grab bar or on top of the toilet tanks that were unlabelled.

According to the licensee's policy IPAC-IV-40, dated October 2018, nail clippers were to be submerged or soaked in disinfectant in accordance with the label instructions and returned to an appropriate storage place. The "storage place" was not identified and no details were provided as to what container the nail clippers needed to be placed in while being submerged.

According to the licensee's policy IPAC-IV-35, dated October 2018, personal care supplies are to be appropriately labelled, cleaned and disinfected and stored in a clothes cupboard or drawer. The policy included avoidance of contact or contamination of personal supplies with contaminated areas. Although contaminated areas were not identified specifically in the policy, they included areas such as toilet tank lids, open surfaces, grab bars, areas next to sinks etc. The policy did not address how small items such as nail clippers should be stored once cleaned (i.e. clearly identified clean container for clean clippers).

The Director of Care identified that she had not addressed the issue of how staff were storing urine measure hats in resident washrooms during the inspection, that it was a planned topic in the near future. The administrator reported that an audit to monitor if staff were following or complying with their infection prevention and control program related to storage and handling of personal care articles in communal spaces was not developed. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 30th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by BERNADETTE SUSNIK (120) - (A2)
Inspection No. / No de l'inspection :	2019_539120_0020 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002461-19, 002471-19, 002472-19, 002473-19, 002474-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 30, 2019(A2)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marci Hutchinson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Maplewood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 30th day of July, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by BERNADETTE SUSNIK (120) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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