Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
Nov 5, 2021	2021_820130_0009	019067-20, 020715-20, 006681-21, 008305-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare St. Catharines
283 Pelham Road St Catherines ON L2S 1X7

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

GILLIAN HUNTER (130), AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 4, 5, 6, 7, 8, 12, 13, 14, 2021.

The following intakes were completed during this complaint inspection:

Log #019067-20 related to plan of care and Logs #020715-20, #006681-21 and #008305-21 related to abuse.

During this inspection the home was toured, provision of care, dining service and medication administration were observed. Clinical records, policies and procedures, critical incident and complaint investigation files were reviewed, staff and residents were interviewed.

Please note: this inspection was conducted concurrently with the following Critical Incident Inspection (2021_820130_0010).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Wound Care Nurse, Resident Assessment Instrument (RAI) Coordinator, Activity Director, Certified Activity Aides, registered staff, personal support workers, housekeepers and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care

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

7 WN(s)
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all allegations of abuse were immediately investigated.

The home confirmed that they had received a number of allegations of abuse by a specified staff member towards residents. Some of the allegations were anonymously reported. Not all of the allegations clearly identified the residents involved in the incidents, only identifying them by initials.

Staff confirmed in an interview that the allegations of abuse of a resident were immediately investigated; however, the allegations of abuse involving seven other residents were not investigated.

There was potential for ongoing abuse and risk of harm to residents by the licensee's inaction to respond, investigate and act on all allegations of abuse.

Sources: Interviews with staff and review of the home's internal investigation file. [s. 23. (1) (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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

The home received an allegation of abuse of a resident by a staff member. The incident was identified to have occurred approximately 10 days prior to the submission of a Critical Incident System Report to the Director.
A second allegation of resident abuse was reported to the home nine days after it was allegedly to have occurred.

The Administrator confirmed the allegations of abuse were not immediately reported to the Director.

A staff member submitted a written letter to the home alleging abuse by staff towards three residents. The same day, a second staff member submitted a written letter alleging abuse by a staff member towards a resident. The Administrator confirmed the alleged abuse toward residents were not reported to the Director.

The home received a third letter, alleging abuse by a staff member towards five residents. Staff verified that not all of the allegations were immediately investigated or reported to the Director.

A staff member reported an allegation of resident abuse by staff to the Ministry via the Info-Line. The staff member confirmed during an interview that they did not immediately report the allegation of abuse, but waited several days before reporting.

The licensee's failure to report the alleged abuse prevented the Director from conducting an inquiry or inspection to ensure compliance with the requirements under this Act.

Sources: Interviews with staff, review of home's investigation notes and clinical records. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 48 (4)b , and in reference to O. Reg. 79/10, s. 52 (1) 4 , the licensee was required to monitor residents responses to and effectiveness of pain management strategies.

Specifically, staff did not comply with the licensee's policy for pain management, which stated:
1. Assess the resident on admission, hospital readmission, for a new diagnosis of painful disease and for a new pain using the comprehensive pain assessment in addition to the use of the pain assessment in advanced dementia (PAINAD) to assess all non-verbal and cognitively- impaired residents.
2. Complete a pain assessment for 72 hours on the day, evening shifts and on nights only if the resident is awake for the following indications;
a. A new pain medication is started;
b. A new non-pharmacological intervention is initiated; and/or
c. Breakthrough pain medication is used for 3 consecutive days.

1. Progress notes indicated that a resident was experiencing new pain with a pain score identified. The electronic medication administration record (EMAR) indicated the resident was administered a pain medication for pain management for eight consecutive days

starting four days after the pain was first documented and subsequently on two occasions each greater than three consecutive days. Further clinical record review did not include a comprehensive pain assessment at the time the resident experienced new pain or when they were administered breakthrough pain medication for three consecutive days or greater. Their last comprehensive pain assessment was completed approximately six months prior.

Staff confirmed that a comprehensive pain assessment on each shift for 72 hours should have been completed when the resident reported new pain as well as when they received breakthrough pain medication for three consecutive days or greater.

The resident was at risk for inadequate pain management when a comprehensive pain assessment was not completed when indicated.

Sources: A resident's electronic medical record, Pain Identification and Management policy, interviews with staff.

2. Progress notes indicated a resident was experiencing pain. The following day it was identified that the resident was experiencing pain to another area and they refused to complete an activity. The EMAR indicated the resident was administered a pain medication for pain management for five consecutive days and subsequently three consecutive days. Further clinical record review did not include the comprehensive pain assessments required at the time that the resident verbalized pain. The resident also did not have comprehensive pain assessments completed when they received breakthrough pain medication for three consecutive days.

Staff confirmed that comprehensive pain assessments should have been completed on each shift for 72 hours when the resident reported new pain as well as when they received breakthrough pain medication for three consecutive days or greater.

The resident was at risk for inadequate pain management when a comprehensive pain assessment was not completed when indicated

Sources: A resident's electronic medical record, Pain Identification and Management policy, interviews with staff. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act and Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident's admission.

According to a complaint, a resident had skin concerns which presented shortly after their admission to the home.

The licensee's skin and wound policy directed registered staff to conduct a comprehensive head to toe assessment for all residents within 24 hours of admission.

Clinical records identified that after the resident was admitted to the home and it was over 10 days later that staff documented that they were at risk for pressure ulcers and required assistance with bed mobility. The resident was also identified to have additional contributing factors related to skin care. Further review of the clinical record did not include a head to toe assessment at the time of admission.

Staff confirmed that on admission all residents were to have head to toe skin assessments completed and that this was not completed for the resident at the time of their admission.

The resident was at risk for an ineffective implementation of individualized skin care interventions when staff did not complete a head to toe assessment on admission.

Sources: Complaint log, a resident's electronic medical record, Skin and Wound Program: Prevention of Skin Breakdown Policy, and interviews with staff. [s. 50. (2) (a) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents at risk of altered skin integrity, receive a skin assessments by a member of the registered nursing staff, within 24 hours of the resident's admission, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse

A complaint was reported that an RPN had requested PSWs to assist them with medication administration by feeding the medication to residents, including a specified resident.

The RPN confirmed that before and during COVID-19 pandemic, when the home was short staffed, they sought help from PSWs to feed residents their medication, including the specified resident because of infection control measures in place.

The Administrator confirmed they were made aware of the practice and that registered staff were reminded of the requirements prohibiting this practice.

There was potential for harm to residents and risk for medication errors when registered staff delegated medication administration to PSWs.

Sources: Interviews with staff. [s. 131. (3)]

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care related to pain management for a resident that set out the planned care for the resident.

Progress notes identified that a resident refused to complete an activity and complained of pain after a fall. The resident was subsequently sent to hospital and diagnosed with an injury. The EMAR indicated the resident was administered medication for pain ten days in the month in addition to their standing order for pain medication. Further clinical record review identified that their care plan was not updated and did not identify pain as a focus or include any goals or interventions until five weeks later.

The licensee's pain policy directed staff to develop and implement a plan of care based on the history and current assessment including the resident's pain control goals and values.

Staff stated that when a resident was exhibiting pain they communicated to other staff via shift reports, documented in the progress notes, that the care plan should be updated, and that in this example a written plan related to pain had not been developed and implemented when the pain was first identified.

Failure to develop a written plan of care that set out the planned care related to pain put the resident at risk for inadequate pain management.

Sources A resident's electronic medical record, Pain Identification and Management policy, interviews with staff. [s. 6. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for a resident was based on an interdisciplinary assessment of their sleep patterns and preferences.

During an interview, a resident stated that staff woke them up each day and that this was not their preferred wake time. A review of the plan of care identified that there was no assessment or planned care related to sleep patterns and preferences, as confirmed by staff.

Sources: Resident and staff interviews and review of clinical record. [s. 26. (3) 21.]

Issued on this 7th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN HUNTER (130), AILEEN GRABA (682)
Inspection No. / No de l'inspection :	2021_820130_0009
Log No. / No de registre :	019067-20, 020715-20, 006681-21, 008305-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 5, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare St. Catharines 283 Pelham Road, St Catherines, ON, L2S-1X7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Freeman

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall be compliant with s. 23 (1) of the LTCHA.

Specifically the licensee must:
ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, is immediately investigated.

Grounds / Motifs :

1. The licensee failed to ensure that all allegations of abuse were immediately investigated.

The home confirmed that they had received a number of allegations of abuse by a specified staff member towards residents. Some of the allegations were anonymously reported. Not all of the allegations clearly identified the residents involved in the incidents, only identifying them by initials.

Staff confirmed in an interview that the allegations of abuse of a resident were immediately investigated; however, the allegations of abuse involving seven other residents were not investigated.

There was potential for ongoing abuse and risk of harm to residents by the licensee's inaction to respond, investigate and act on all allegations of abuse.

Sources: Interviews with staff and review of the home's internal investigation file. [s. 23. (1) (a)]

An order was made by taking the following factors into account:
Severity: The home received allegations of abuse from at least four sources that were not investigated.
Scope: The allegations were widespread as greater than 3 residents were affected.
Compliance History: In the last 36 months, there was no issuance to this section. Five other (compliance orders) CO were issued to different sections of the legislation, which have been complied.

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with s. 24 of the LTCHA.

Specifically the licensee must:
ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it is based to the Director; and
consider information provided, by any source including staff, as potential grounds to suspect abuse or neglect of residents.

Grounds / Motifs :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

The home received an allegation of abuse of a resident by a staff member. The incident was identified to have occurred approximately 10 days prior to the submission of a Critical Incident System Report to the Director.

A second allegation of resident abuse was reported to the home nine days after it was allegedly to have occurred.

The Administrator confirmed the allegations of abuse were not immediately reported to the Director.

A staff member submitted a written letter to the home alleging abuse by staff towards three residents. The same day, a second staff member submitted a written letter alleging abuse by a staff member towards a resident. The Administrator confirmed the alleged abuse toward residents were not reported to the Director.

The home received a third letter, alleging abuse by a staff member towards five residents. Staff verified that not all of the allegations were immediately investigated or reported to the Director.

A staff member reported an allegation of resident abuse by staff to the Ministry via the Info-Line. The staff member confirmed during an interview that they did not immediately report the allegation of abuse, but waited several days before reporting.

The licensee's failure to report the alleged abuse prevented the Director from conducting an inquiry or inspection to ensure compliance with the requirements under this Act.

Sources: Interviews with staff, review of home's investigation notes and clinical records. [s. 24. (1)]

An order was made by taking the following factors into account:
Severity: The home received allegations of abuse from at least three sources that were not immediately reported.
Scope: The allegations were widespread as greater than 3 residents were affected.
Compliance History: In the last 36 months, there was a WN issued to the same section. Five other (compliance orders) CO were issued to different sections of the legislation, which have been complied.

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

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 16, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 5th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Hunter

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