Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 09, 2018;	2018_661683_0008 (A1)	005102-18, 005525-18	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Compliance Due Date was changed from August 13, 2018, to September 3, 2018, at the request of the home.

Issued on this 9 day of August 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 16, 19, 20, 21, 22, 2018. Please note this inspection was completed off-site.

The following intakes were completed as part of this inspection:

005102-18 related to Admission and Discharge

005525-18 related to Admission and Discharge

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), the Local Health Integration Network (LHIN) and families.

During the course of the inspection, the inspector reviewed resident clinical records and a notice of discharge.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Legendé 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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

Before discharging a resident under subsection 145(1) of the LTCHA, the licensee failed to:
(a) ensure that alternatives to discharge were considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; and
(c) ensure the resident and the resident's substitute decision-maker, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

A review of the written plan of care for resident #001 identified that they demonstrated physical and verbal responsive behaviours and that they were at risk for resident to resident altercations or injury.

An interview with the Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC) and review of the clinical records provided by the home indicated that on an identified date, resident #001 demonstrated signs of physical and verbal responsive behaviours. The resident was transferred to hospital for an assessment. As per the progress note, the DRC identified that the resident was not to return to the home until they spoke with the nurse liaison and with the approval of the physician.

At the hospital, resident #001 received an identified diagnosis and the hospital was prepared to send the resident back to Hardy Terrace. The DRC identified to the hospital's Patient Navigation office the resident's history of responsive behaviours and the hospital's Patient Navigation office inquired as to whether the 60-day long-term care reintegration program could be considered for resident #001. In an interview with the resident's primary care physician on an identified date, they indicated that the home felt they were unable to meet resident #001's care needs and they were not able to ensure the safety of resident #001 and other residents at Hardy Terrace. The primary care physician identified that they felt the 60-day long-term care reintegration program was not appropriate for the resident for identified reasons. The physician also identified concerns related to communication strategies for resident #001.

As a result, resident #001 was discharged from the home on an identified date and a discharge letter was sent to resident #001's Power of Attorney (POA). According to the determination of the Inspector, the home discharged resident #001 pursuant to s. 145 (1) of O. Reg 79/10.

As a result of the discharge, a complaint was received by the Ministry of Health and Long-Term Care regarding a wrongful discharge of resident #001. At the time of the inspection, resident #001 remained in hospital awaiting return to Hardy Terrace.

On an identified date, the Local Health Integration Network (LHIN) faxed a copy of the behavioural assessments that had been completed on resident #001 since admission to hospital. A review of the behavioural assessment from an identified date indicated triggers for the resident's physical aggression, identified specific interventions for which resident #001 responded to positively and identified a specific approach as being paramount in managing resident #001's responsive behaviours. A review of BSO consultation follow up notes from two identified dates while the resident was in hospital included a number of specific recommendations

for resident #001's behaviours.

A. An interview with the DRC and review of the clinical record identified that on an identified date, a "910" meeting was held, which the DRC identified the home had when resident behaviours escalated. In attendance for the meeting were the nurse liaison, Alzheimer's Society, recreation staff, Behaviour Support Ontario (BSO), Resident Assessment Instrument (RAI) Coordinator and a registered staff member. The progress note from the meeting on an identified date identified 12 specific interventions for resident #001's care related to their behaviours.

An interview with the DRC on an identified date and review of the progress notes identified that nine of the specific interventions had been completed and/or tried. One of the identified interventions was completed after resident #001 was discharged from the home on an identified date.

A progress note documented by RN #101 from an identified date indicated that a referral had previously been made to a specific outside resource, but no referral was found on the resident's medical chart. As a result, consent was obtained from resident #001's POA and a new referral was made on an identified date. The DRC identified that the home had not yet completed two of the identified interventions and despite the referral being sent, the resident had not been seen by the specific outside resource prior to their discharge on an identified date.

An interview with the DRC on an identified date and review of a progress note from an identified date indicated that the DRC spoke with the Patient Navigation office from an identified hospital who indicated that the resident was admitted with a specific diagnosis. The DRC identified to the Patient Navigation office that the resident had responsive behaviours and noted that they had been increasing over several months. The hospital's Patient Navigation office inquired whether the 60-day long-term care reintegration could be considered for resident #001. A conference call was held with the home's interdisciplinary team on an identified date and resident #001's primary physician decided that they did not want to move forward with the 60-day long-term care reintegration because they believed that the resident required more intensive therapy. On an identified date, the physician provided a telephone order to discharge resident #001 from Hardy Terrace.

Before discharging resident #001 under subsection 145(1), the home did not ensure that alternatives to discharge were considered and where appropriate, tried. This included the home not completing two of the identified interventions, having

an assessment by an identified outside resource, exploring high intensity funding for one to one staffing in relation to resident #001 and use of the 60-day long-term care reintegration program.

B. An interview with the DRC on an identified date indicated that resident #001's responsive behaviours increased since an identified month, and the home considered discharging resident #001 at that time. The DRC identified that they were in contact with the Local Health Integration Network (LHIN) regarding resident #001 and acknowledged that during the identified month, the resident was on the wait list for other homes.

An interview with the DRC and review of the clinical record identified that at the meeting held on an identified date, the following members of the interdisciplinary team were present: the nurse liaison, Alzheimer's Society, recreation staff, BSO, RAI Coordinator and a registered staff member. Progress notes from two consecutive days identified that the POA and a representative for the POA for resident #001 were notified that the resident could be discharged by the home if they caused any harm to co-residents or staff.

The Inspector requested documentation regarding conversations with the LHIN in relation to a possible discharge of the resident. The DRC identified that they did not have any documentation of conversations with the LHIN in relation to resident #001, aside from a progress note which was documented after the resident was sent to hospital for assessment. The progress note, from an identified date, indicated that a call was placed to the LHIN placement coordinator regarding possible discharge of resident #001 due to ongoing responsive behaviours. The LHIN placement coordinator identified to the DRC that resident #001's file was closed in an identified month, and that if discharge occurred, a new application to a long-term care home needed to be initiated.

An interview with the LHIN placement coordinator on an identified date, indicated that the LHIN had no conversation with the home about a potential discharge prior to the resident coming to the hospital. They identified that they felt the resident should not have been discharged from the home and noted that in the hospital, the resident received a specific diagnosis, for which they felt contributed to their behaviours. They identified that they were not looking into other homes for the resident and that the family expected the resident to return to the home.

The home did not ensure that before discharging resident #001 under subsection

145(1), that they collaborated with the appropriate placement co-ordinator and that alternative arrangements for the accommodation, care and secure environment required by resident #001 were made.

C. An interview with the DRC on an identified date, indicated that resident #001's behaviours increased since an identified month and the home considered discharge since that time. They acknowledged that in the identified month, the resident was on the wait list for other long-term care homes. Interview with the DRC on an identified date, acknowledged that they did not have a conversation with the POA of resident #001 in the identified month about the potential for discharge of resident #001. They identified that the conversation may have occurred with the responsive behaviours team lead at that time, however; there was no documentation of such a conversation.

An interview with the DRC and review of the progress note from the meeting held on an identified date indicated that it was difficult to contact resident #001's POA, however; there was no evidence of any other type of communication attempted to set up a meeting with the POA.

Progress notes were reviewed for a three month span. On two consecutive days, the POA and a representative of the POA for resident #001 were notified that the resident could be discharged by the home if they caused any harm to co-residents or staff. Review of the progress notes identified that the POA was notified of a potential discharge, however; did not identify that an opportunity to participate in the discharge planning was offered or that this occurred.

An interview with the complainant on an identified date indicated that they were not aware of any conversations regarding planning alternative placement for resident #001, noting that they were highly involved with communication between the POA and the home. An interview with the POA and substitude-decision maker of resident #001 identified that they were told about potential discharge due to resident #001's behaviour, but indicated that they did not have any communication with the home related to alternative placement or discharge planning, and that their input was not sought in relation to any discharge planning for resident #001.

The home did not ensure that before discharging resident #001 under subsection 145(1), the resident's substitute decision maker was given an opportunity to participate in the discharge planning and that their wishes were taken into consideration.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 9 day of August 2018 (A1)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by LISA BOS (683) - (A1)

Inspection No. / No de l'inspection : 2018_661683_0008 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005102-18, 005525-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 09, 2018;(A1)

Licensee / Titulaire de permis : Diversicare Canada Management Services Co., Inc.
2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4

LTC Home / Foyer de SLD : Hardy Terrace
612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paul Rooyakkers

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 Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 148.

In the case of resident #001, the licensee shall:
a) Work with the hospital and Local Health Integration Network (LHIN) to participate fully in the hospital discharge plans for resident #001.
b) Review the behavioural assessments completed while the resident was in the hospital and implement the suggestions from Behavioural Supports Ontario (BSO).

If resident #001 is to be discharged in the future, the licensee shall ensure that the following are met prior to discharge:
a) Alternatives to discharge have been considered and, where appropriate, tried.
b) In collaboration with the appropriate placement co-coordinator and other health services organizations, alternative arrangements are made for the accommodation, care and secure environment required by the resident.
c) That resident #001, their Substitute Decision-Maker (SDM) and any other person either of them may direct are kept informed and given an opportunity to participate in the discharge planning.

Grounds / Motifs :

1. Before discharging a resident under subsection 145(1) of the LTCHA, the licensee failed to:
(a) ensure that alternatives to discharge were considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; and
(c) ensure the resident and the resident's substitute decision-maker, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

A review of the written plan of care for resident #001 identified that they demonstrated physical and verbal responsive behaviours and that they were at risk for resident to resident altercations or injury.

An interview with the Director of Resident Care (DRC), Assistant Director of Resident

Care (ADRC) and review of the clinical records provided by the home indicated that on an identified date, resident #001 demonstrated signs of physical and verbal responsive behaviours. The resident was transferred to hospital for an assessment. As per the progress note, the DRC identified that the resident was not to return to the home until they spoke with the nurse liaison and with the approval of the physician.

At the hospital, resident #001 received an identified diagnosis and the hospital was prepared to send the resident back to Hardy Terrace. The DRC identified to the hospital's Patient Navigation office the resident's history of responsive behaviours and the hospital's Patient Navigation office inquired as to whether the 60-day long-term care reintegration program could be considered for resident #001. In an interview with the resident's primary care physician on an identified date, they indicated that the home felt they were unable to meet resident #001's care needs and they were not able to ensure the safety of resident #001 and other residents at Hardy Terrace. The primary care physician identified that they felt the 60-day long-term care reintegration program was not appropriate for the resident for identified reasons. The physician also identified concerns related to communication strategies for resident #001.

As a result, resident #001 was discharged from the home on an identified date and a discharge letter was sent to resident #001's Power of Attorney (POA). According to the determination of the Inspector, the home discharged resident #001 pursuant to s. 145 (1) of O. Reg 79/10.

As a result of the discharge, a complaint was received by the Ministry of Health and Long-Term Care regarding a wrongful discharge of resident #001. At the time of the inspection, resident #001 remained in hospital awaiting return to Hardy Terrace.

On an identified date, the Local Health Integration Network (LHIN) faxed a copy of the behavioural assessments that had been completed on resident #001 since admission to hospital. A review of the behavioural assessment from an identified date indicated triggers for the resident's physical aggression, identified specific interventions for which resident #001 responded to positively and identified a specific approach as being paramount in managing resident #001's responsive behaviours. A review of BSO consultation follow up notes from two identified dates while the resident was in hospital included a number of specific recommendations for resident #001's behaviours.

A. An interview with the DRC and review of the clinical record identified that on an identified date, a "910" meeting was held, which the DRC identified the home had when resident behaviours escalated. In attendance for the meeting were the nurse liaison, Alzheimer's Society, recreation staff, Behaviour Support Ontario (BSO), Resident Assessment Instrument (RAI) Coordinator and a registered staff member. The progress note from the meeting on an identified date identified 12 specific interventions for resident #001's care related to their behaviours.

An interview with the DRC on an identified date and review of the progress notes identified that nine of the specific interventions had been completed and/or tried. One of the identified interventions was completed after resident #001 was discharged from the home on an identified date.

A progress note documented by RN #101 from an identified date indicated that a referral had previously been made to a specific outside resource, but no referral was found on the resident's medical chart. As a result, consent was obtained from resident #001's POA and a new referral was made on an identified date. The DRC identified that the home had not yet completed two of the identified interventions and despite the referral being sent, the resident had not been seen by the specific outside resource prior to their discharge on an identified date.

An interview with the DRC on an identified date and review of a progress note from an identified date indicated that the DRC spoke with the Patient Navigation office from an identified hospital who indicated that the resident was admitted with a specific diagnosis. The DRC identified to the Patient Navigation office that the resident had responsive behaviours and noted that they had been increasing over several months. The hospital's Patient Navigation office inquired whether the 60-day long-term care reintegration could be considered for resident #001. A conference call was held with the home's interdisciplinary team on an identified date and resident #001's primary physician decided that they did not want to move forward with the 60-day long-term care reintegration because they believed that the resident required more intensive therapy. On an identified date, the physician provided a telephone order to discharge resident #001 from Hardy Terrace.

Before discharging resident #001 under subsection 145(1), the home did not ensure that alternatives to discharge were considered and where appropriate, tried. This included the home not completing two of the identified interventions, having an assessment by an identified outside resource, exploring high intensity funding for one

to one staffing in relation to resident #001 and use of the 60-day long-term care reintegration program.

B. An interview with the DRC on an identified date indicated that resident #001's responsive behaviours increased since an identified month, and the home considered discharging resident #001 at that time. The DRC identified that they were in contact with the Local Health Integration Network (LHIN) regarding resident #001 and acknowledged that during the identified month, the resident was on the wait list for other homes.

An interview with the DRC and review of the clinical record identified that at the meeting held on an identified date, the following members of the interdisciplinary team were present: the nurse liaison, Alzheimer's Society, recreation staff, BSO, RAI Coordinator and a registered staff member. Progress notes from two consecutive days identified that the POA and a representative for the POA for resident #001 were notified that the resident could be discharged by the home if they caused any harm to co-residents or staff.

The Inspector requested documentation regarding conversations with the LHIN in relation to a possible discharge of the resident. The DRC identified that they did not have any documentation of conversations with the LHIN in relation to resident #001, aside from a progress note which was documented after the resident was sent to hospital for assessment. The progress note, from an identified date, indicated that a call was placed to the LHIN placement coordinator regarding possible discharge of resident #001 due to ongoing responsive behaviours. The LHIN placement coordinator identified to the DRC that resident #001's file was closed in an identified month, and that if discharge occurred, a new application to a long-term care home needed to be initiated.

An interview with the LHIN placement coordinator on an identified date, indicated that the LHIN had no conversation with the home about a potential discharge prior to the resident coming to the hospital. They identified that they felt the resident should not have been discharged from the home and noted that in the hospital, the resident received a specific diagnosis, for which they felt contributed to their behaviours. They identified that they were not looking into other homes for the resident and that the family expected the resident to return to the home.

The home did not ensure that before discharging resident #001 under subsection

145(1), that they collaborated with the appropriate placement co-ordinator and that alternative arrangements for the accommodation, care and secure environment required by resident #001 were made.

C. An interview with the DRC on an identified date, indicated that resident #001's behaviours increased since an identified month and the home considered discharge since that time. They acknowledged that in the identified month, the resident was on the wait list for other long-term care homes. Interview with the DRC on an identified date, acknowledged that they did not have a conversation with the POA of resident #001 in the identified month about the potential for discharge of resident #001. They identified that the conversation may have occurred with the responsive behaviours team lead at that time, however; there was no documentation of such a conversation.

An interview with the DRC and review of the progress note from the meeting held on an identified date indicated that it was difficult to contact resident #001's POA, however; there was no evidence of any other type of communication attempted to set up a meeting with the POA.

Progress notes were reviewed for a three month span. On two consecutive days, the POA and a representative of the POA for resident #001 were notified that the resident could be discharged by the home if they caused any harm to co-residents or staff. Review of the progress notes identified that the POA was notified of a potential discharge, however; did not identify that an opportunity to participate in the discharge planning was offered or that this occurred.

An interview with the complainant on an identified date indicated that they were not aware of any conversations regarding planning alternative placement for resident #001, noting that they were highly involved with communication between the POA and the home. An interview with the POA and substitude-decision maker of resident #001 identified that they were told about potential discharge due to resident #001's behaviour, but indicated that they did not have any communication with the home related to alternative placement or discharge planning, and that their input was not sought in relation to any discharge planning for resident #001.

The home did not ensure that before discharging resident #001 under subsection 145(1), the resident's substitute decision maker was given an opportunity to participate in the discharge planning and that their wishes were taken into consideration.

The severity of this issue was determined to be a level 3 as there was actual harm / risk to the resident. The scope of the issue was a level 1 as it was related to one resident. The home had a level 3 compliance history of a previous WN in a similar area that included:

• Written notification (WN) issued July 19, 2016, (2016_275536_0014) (683)

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

Sep 03, 2018(A1)

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:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 9 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LISA BOS - (A1)

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

Service Area Office / Bureau régional de services : Hamilton