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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2021	2021_689586_0022	002939-21, 003462-21, 007139-21	Critical Incident System

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive Stoney Creek ON L8J 2J3

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

Heritage Green Nursing Home
353 Isaac Brock Drive Stoney Creek ON L8J 2J3

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

JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 16, 20, 21, 22, 23, 26, 27, 28, 29 and August 3 and 4, 2021.

Inspectors #916 and #926 were present and shadowing during the inspection.

During the course of the inspection, the following Critical Incident System (CIS) inspection were completed concurrently:

007139-21 (CIS #2776-000012-21) and 003462-21 (CIS #2776-000003-21) related to falls with significant injury; and,
002939-21 (CIS #2776-000002-21) related to a choking incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistance Administrator (AA), Director of Care (DOC), Clinical Coordinator (CC), Staff Development Coordinator (SDC), Dietary Manager (DM), Food Service Supervisor (FSS), Maintenance Supervisor (MS), Occupational Therapist (OT), Physiotherapist (PT), physiotherapy assistants (PTA), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, dietary staff and residents.

During the course of the inspection, the inspector(s) toured the home, completed mandatory Infection Prevention and Control (IPAC) and cooling requirement checklists, observed meal service and food production, observed resident care and reviewed resident records, relevant policies and procedures, program evaluations, audits and training materials and attendance records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

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

- **6 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration program was evaluated and updated at least annually.

In an interview with the DM and the CC, it was confirmed that the nutrition and hydration program was not evaluated for 2019 or 2020.

Sources: interviews with RD, FSS, DM, CC and AA. [s. 30. (1) 3.]

2. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments and interventions and the resident's responses to interventions was documented.

A) Resident #002 was at a high risk for falls. In an interview with the SDC, they said that the resident was discussed at the monthly Fall Committee Meetings; however, the discussion of the assessments and interventions were not documented in the meeting minutes or in the resident's clinical record.

Upon review of the resident's clinical record, there was no evidence to support that each fall incident was discussed by the nursing staff or that the resident's fall prevention plan of care was reviewed after each fall. Eleven of the falls did not have any documentation to demonstrate that the fall was reviewed by the interdisciplinary team and/or required any care plan changes.

B) Resident #003 was at a high risk for falls. In an interview with the SDC, they said that the resident was discussed at the monthly Fall Committee Meetings; however, the discussion of the assessments and interventions were not documented in the meeting minutes or in the resident's clinical record.

C) Eleven paper copies of head injury routines (HIR) completed post-fall for resident #002 were dated with the day and month; however, did not include the year. The SDC acknowledged that this was incomplete documentation by staff, as it could not be verified exactly which corresponding falls these were completed for.

There was no documentation to demonstrate what fall prevention strategies were discussed for the residents.

Sources: residents' clinical records and interview with the SDC. [s. 30. (2)]

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. 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) Resident #002 was at a high risk for falls.

i. The resident had a trend of falls over a three-month period; however, an OT referral was not made by nursing staff until two months after that. In an interview with the DOC and SDC, both acknowledged that a referral should have been sent sooner to OT to reassess the appropriateness of the wheelchair and develop potential interventions

based on assessment.

ii. A second OT referral was sent; however, OT did not complete either assessment. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referrals were sent but were not acted upon, and the resident was not assessed.

iii. When the above referrals were not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

B) Resident #003 was at a high risk for falls.

i. An OT referral was sent as a result of an injury the resident sustained from a fall. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referral was sent but was not acted upon, and the resident was not assessed.

ii. When the above referral was not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

C) Resident #004 was at a high risk for falls.

i. An OT referral was sent post-fall due to a recommendation by the PT. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referral was sent but was not acted upon, and the resident was not assessed.

ii. When the above referral was not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

Not assessing the resident for the use of an appropriate wheelchair posed a risk of experiencing issues from the chair.

The resident plans of care were not based on assessments of the residents, posing a risk of the residents' needs not being met related to fall prevention.

Sources: residents' clinical records and interview with OT and other staff. [s. 6. (2)]

3. The licensee has failed to ensure that a resident was reassessed and the care plan revised when the care set out in the plan of care had not been effective.

The resident was at a high risk for falls and experienced several falls in 2020 and 2021. A review of the resident's plan of care confirmed that there were no revisions made regarding falls until after the tenth fall within that time period. In an interview with the SDC, they confirmed that revisions to the care plan were not made after each fall, or record to show that the plan was reviewed but no revisions were required.

Sources: a resident's clinical record and interview with the SDC and other staff. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 every resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective, to be implemented voluntarily.

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 has failed to ensure that the home's head injury routine (HIR) policy was complied with.

In accordance with O. Reg 79/10, s. 30 (1) 1, the licensee is required to develop relevant policies, procedures and protocols for each of the interdisciplinary programs as required under section 48 of the Regulation; specifically, s. 49, fall prevention and management.

The licensee's policy, 'Neurological Signs: Head Injury Routine' directed staff to complete a HIR when a resident experienced an unwitnessed fall or had a suspected or confirmed head injury, as early recognition and treatment provided the best chance of halting deterioration before irreversible damage developed.

A resident experienced unwitnessed falls on two dates, in addition to another fall whereby they sustained a head injury. They also experienced a witnessed fall on another day where it was observed that they hit their head.

HIRs for the above dates could not be located upon review of the resident's clinical record. This was confirmed by the SDC

Not completing HIRs pose a risk of not identifying neurological changes post-fall.

Sources: a resident's clinical record, the licensee's policy, 'Neurological Signs: Head Injury Routine' (08-01-27) and interview with staff. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system put into place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's temperature was measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home.

The Administrator and MS confirmed that temperatures were not being taken in resident rooms.

Sources: interview with Administrator and MS. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the home's temperature was measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The Administrator and MS confirmed that temperatures in resident common areas were only measured once per day, around 11 a.m.

Sources: interview with Administrator and MS. [s. 21. (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 the home's temperature is measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident for which a resident was taken to the hospital and resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

A resident experienced a medical emergency and was taken to the hospital by Emergency Medical Services (EMS). The following day, the long-term care home (LTCH) staff were informed that the resident would be returning to the LTCH that day with palliative measures in place.

According to the CIS report and interview with the SDC, it was confirmed that the Director was not notified of the incident until eight business days later.

Sources: CIS 2776-000002-21, a resident's health record and interview with SDC. [s. 107. (3) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a training and orientation program for the home was developed and implemented to provide the training and orientation required under section 76 of the Act; specifically, s. 76 (2) 10; all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

In an interview with the DM and FSS, it was confirmed that the home completed verbal and demonstrative training for dietary staff upon hire, but did not have a formal process in place. The current process did not include review of internal policies and procedures by staff, there was no educational content or material available and no training records completed or kept.

Sources: interview with the Dietary Manager and FSS. [s. 216. (1)]

Issued on this 1st day of September, 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) :	JESSICA PALADINO (586)
Inspection No. / No de l’inspection :	2021_689586_0022
Log No. / No de registre :	002939-21, 003462-21, 007139-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 27, 2021
Licensee / Titulaire de permis :	Heritage Green Nursing Home 353 Isaac Brock Drive, Stoney Creek, ON, L8J-2J3
LTC Home / Foyer de SLD :	Heritage Green Nursing Home 353 Isaac Brock Drive, Stoney Creek, ON, L8J-2J3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	J. Scott Kozachenko

To Heritage Green Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The licensee must comply with s. 30 (2) of O. Reg. 79/10.

Specifically, the licensee shall ensure that:

1. The monthly Fall Committee Meeting minutes, including what was discussed for each resident who fell that month, are completed each month; and,

2. Documentation in the respective resident's clinical health record of the multidisciplinary post-fall huddle after each fall, including root cause analysis and prevention of future occurrence, is completed.

Grounds / Motifs :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments and interventions and the resident's responses to interventions was documented.

A) Resident #002 was at a high risk for falls. In an interview with the SDC, they said that the resident was discussed at the monthly Fall Committee Meetings; however, the discussion of the assessments and interventions were not documented in the meeting minutes or in the resident's clinical record.

Upon review of the resident's clinical record, there was no evidence to support that each fall incident was discussed by the nursing staff or that the resident's fall prevention plan of care was reviewed after each fall. Eleven of the falls did not have any documentation to demonstrate that the fall was reviewed by the interdisciplinary team and/or required any care plan changes.

B) Resident #003 was at a high risk for falls. In an interview with the SDC, they said that the resident was discussed at the monthly Fall Committee Meetings; however, the discussion of the assessments and interventions were not documented in the meeting minutes or in the resident's clinical record.

C) Eleven paper copies of head injury routines (HIR) completed post-fall for resident #002 were dated with the day and month; however, did not include the year. The SDC acknowledged that this was incomplete documentation by staff, as it could not be verified exactly which corresponding falls these were completed for.

There was no documentation to demonstrate what fall prevention strategies were discussed for the residents.

Sources: residents' clinical records and interview with the SDC.

An order was made by taking the following factors into account:

Severity: There was risk of harm by not documenting the residents' plans of care for the interdisciplinary team.

Scope: This non-compliance was a pattern as two of three residents reviewed for falls resulted in non-compliance with this section of the legislation.

Compliance History:There was a written notification (WN) and voluntary plan of correction (VPC) issued in the same area of the legislation in the past 36 months. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee must comply with s. 6 (2) of the LTCHA.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that care set out in resident #003's and #004's plan of care is based on an assessment of the residents and the needs and preferences of the residents.

The plan must include but is not limited to, processes to ensure that:

1. Nursing, physiotherapy and occupational therapy (OT) staff communicate on a regular basis to discuss relevant resident needs and to ensure that necessary referrals are made within an appropriate time frame;

2. OT will assess all residents that they have received referrals for; and,

3. Multidisciplinary staff follow up on any outstanding referrals.

4. Re-education must be provided for registered staff on these processes. A record of this training must be kept, including the date and a signature of the persons who attended.

Please submit the written plan for achieving compliance for inspection #2021_689586_0022 to Jessica Paladino, LTC Homes Inspector, MLTC, by email to HamiltonSAO.MOH@Ontario.ca by September 10, 2021. Please ensure
that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) Resident #002 was at a high risk for falls.

i. The resident had a trend of falls over a three-month period; however, an OT referral was not made by nursing staff until two months after that. In an interview with the DOC and SDC, both acknowledged that a referral should have been sent sooner to OT to reassess the appropriateness of the wheelchair and develop potential interventions based on assessment.

ii. A second OT referral was sent; however, OT did not complete either assessment. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referrals were sent but were not acted upon, and the resident was not assessed.

iii. When the above referrals were not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

B) Resident #003 was at a high risk for falls.

i. An OT referral was sent as a result of an injury the resident sustained from a fall. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referral was sent but was not acted upon, and the resident was not assessed.

ii. When the above referral was not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

C) Resident #004 was at a high risk for falls.

i. An OT referral was sent post-fall due to a recommendation by the PT. Upon review of the resident's clinical record and interview with the OT, they acknowledged that the referral was sent but was not acted upon, and the

resident was not assessed.

ii. When the above referral was not acted upon by OT, nursing staff did not follow up on the statuses of the referrals. The DOC said that it was the expectation of the home that registered staff follow up on outstanding referrals.

Not assessing the resident for the use of an appropriate wheelchair posed a risk of experiencing issues from the chair.

The resident plans of care were not based on assessments of the residents, posing a risk of the residents' needs not being met related to fall prevention.

Sources: residents' clinical records and interview with OT and other staff.

An order was made by taking the following factors into account:

Severity: There was risk of harm because the residents required assessments.

Scope: This non-compliance was widespread as three residents reviewed for falls resulted in non-compliance with this section of the legislation.

Compliance History: Non-compliance was issued to the home related to different sections of the legislation in the past 36 months. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 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
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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

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

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

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

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

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

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

Issued on this 27th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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