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 26, 2021	2021_725522_0013	010855-21, 015350-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

The Maples Home for Seniors
94 William Street South P.O. Box 400 Tavistock ON N0B 2R0

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

JULIE LAMPMAN (522)

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): October 27, 28, November 1, 2, 8, 9, 10 and 15, 2021.

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

CIS #2093-000010-21/ Log #015350-21 related to falls prevention;
CIS #2093-000006-21/ Log #010855-21 related to allegations of neglect.

Complaint Inspection #2021_725522_0014 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Activity Director, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers, a Physiotherapist, a Physiotherapist Aide, a Housekeeper, Screeners, a Contractor and a resident.

The inspector also observed infection prevention and control practices in the home, staff to resident interactions, the provision of resident care; reviewed resident clinical records, the home's investigative notes, staff training records, and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) Review of the home's "Job Tasks – COVID-19 Door Screener" policy noted in part, that Screener's were to don Personal Protective Equipment (PPE) including a gown, mask, shield and gloves; unless behind plexiglass; in which case they required a mask only.

On a specific date, Inspector #522 was let into a small foyer by Screener #105 who was only wearing a face mask. There was no plexiglass barrier between Screener #105 and the inspector.

The following day, Inspector #522 was screened by the Director of Care (DOC) who was wearing a face mask and gown, but no eye protection. Inspector #522 also observed Screener #106 screen staff and visitors without eye protection.

In interviews, Screener #105 and Screener #106 both stated they did not wear eye protection while they completed screening of staff and visitors. Screener #105 also stated at times when they were busy, they would forget to put on a gown.

In an interview, the DOC stated the screeners were expected to wear a gown and face mask.

B) Review of the home's "Donning and Doffing of Personal Protective Equipment" policy noted the following in part:

Staff were to always perform hand hygiene immediately before they donned and after they doffed their PPE.
When staff donned a gown, it was to be secured at the neck and waist.
When staff doffed a gown, the gown front and sleeves were considered dirty and staff were to turn the contaminated outside surface of the gown toward the inside and roll the gown into a bundle.

i) On a specific date, Inspector #522 observed Screener #105 on several occasions don and doff their PPE inappropriately.

In an interview, Screener #105 stated they did not know the proper way to don and doff a gown and acknowledged that they had not removed their mask properly when they took

a drink.

ii) The following day, Inspector #522 was screened by the DOC who was wearing a gown that had not been tied.

In an interview, the DOC stated when staff wore a gown it should be tied at the neck and waist and staff should hand sanitize when they donned and doffed PPE and staff should remove their mask when they drank. The DOC stated if staff used a disposable gown it should be disposed of properly after use.

C) Review of the home's "Hand Hygiene" policy noted hand hygiene must be performed after removing PPE and after contact with a resident or items in their immediate surroundings and when leaving the resident even if the resident has not been touched.

i) On a specific date, Inspector #522 observed the Activity Director (AD) wheel a resident in a wheelchair into the resident's room. The AD left the resident’s room and did not sanitize their hands.

In an interview, the AD acknowledged they had wheeled the resident into their room and did not sanitize their hands when they left the resident and they should have.

ii) On a specific date, observations of Screener #105 noted on numerous occasions the Screener did not sanitize their hands when they removed their gown and after they touched their mask.

In an interview, Screener #105 acknowledged they did not sanitize their hands when they removed their gown and pulled down their mask and were unsure of the process for hand hygiene when they removed their PPE.

In an interview, the DOC stated staff should hand sanitize when they donned and doffed PPE and when they left a resident’s room after they portered a resident.

D) Review of the home’s “COVID-19 Surveillance and Access to LTC Homes” policy noted when registered staff completed surveillance testing in the home, they were to wear PPE, including a gown, surgical mask, eye protection and gloves.

On a specific date, Inspector #522 observed Registered Nurse (RN) #102 perform a rapid antigen test on a contractor outside of the home. RN #102 was observed with only

a face mask on.

In an interview, RN #102 stated they normally wore full PPE when they completed a rapid antigen test, but since they had performed the rapid antigen test on the contractor outside of the home they only wore a face mask and gloves.

In an interview, the DOC stated staff should always wear full PPE, including a gown, gloves, face mask and goggles, when they completed a rapid antigen test.

E) Review of the home's "Management of COVID-19 – Staff Roles & Responsibilities" policy noted in part that the Personnel assigned to the entrance of the home would conduct active screening on all team members, volunteers, contractors, and visitors to the home as outlined by Public Health Units.

Review of Directive #3 for Long-Term Care Homes (LTCH) under the Long-Term Care Homes Act, 2007 noted anyone wishing to enter a LTCH must be actively screened prior to being permitted entry into the LTCH. Directive #3 stated LTCHs must following the COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes.

The Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes noted at a minimum, the following questions should be asked to screen individuals for COVID-19 before entry - if the person had any new or worsening symptoms of fever and/or chills, cough or barking cough (croup), shortness of breath, decrease or loss of smell or taste, fatigue. lethargy, malaise and/or myalgias.

On several occasions during the inspection, Screener #105 and Screener #106 were observed screening visitors and staff members. Screener #105 and Screener #106 did not ask all of the visitors and staff members if they had typical and atypical symptoms of COVID-19. The Screeners were observed asking only if the person had any symptoms.

In an interview, Screener #105 confirmed there was a list of typical and atypical symptoms of COVID-19 as part of their screening questions on their laptop.

In an interview, Screener #106 stated if they screened a visitor they would ask about the typical and atypical symptoms of COVID-19, but for staff they did not go through the whole question as staff knew them. Screener #106 stated it was too busy when staff were coming in to go through the whole question.

In an interview, the DOC stated the Screener's should ask about typical and atypical symptoms of COVID-19 when screening staff and visitors.

Not following the home's infection prevention and control (IPAC) policies put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources:

IPAC observations of the home, review of Directive #3 for Long-Term Care Homes (LTCH) under the Long-Term Care Homes Act, 2007, the Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes Version 6 – August 27, 2021, the home's "Job Tasks – COVID-19 Door Screener" policy dated August 6, 2021; the home's "Donning and Doffing of Personal Protective Equipment" with a review date of April, 2018, the home's "Hand Hygiene" policy reviewed/revised September 2020, the home's "COVID-19 Surveillance and Access to LTC Homes" policy reviewed/revised March 2021, and the home's "Management of COVID-19 – Staff Roles & Responsibilities" policy; interviews with Screener #105, Screener #106, RN #102, the Activity Director, the DOC and the Executive Director. [s. 229. (4)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when a contractor was working onsite in the home.

On a specific date and time, Inspector #522 observed a ladder with a screw driver on it and an open work bag with a number of tools including screw drivers unattended in the first floor lounge. Of note there were resident rooms directly off the lounge.

After approximately five minutes, a contractor came into the lounge from the stairwell.

In an interview, the contractor stated they were working by themselves and had just gone outside to their truck so they did not put their tools away.

In an interview, the Director of Care (DOC) stated if a contractor needed to leave the area they were working in they should have gotten the maintenance staff or staff on the floor to watch their things. The DOC stated tools or equipment should never be left unattended due to resident safety and went immediately to speak with the contractor.

Sources:
Observations of home areas and interviews with a Georgian Bay Fire and Safety Technician, the DOC and other staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is a safe and secure environment for its residents when contractors are working onsite in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was free from neglect by Personal Support Worker #107.

Ontario Regulation 79/10 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care by the home related to allegations that resident #002 did not receive continence care during a specific shift.

In an interview, Personal Support Workers (PSWs) #103 and #104 stated when they started their shift on a specific date, they found resident #002 visibly soaked with urine and stool.

In an interview, PSW #107 acknowledged they had checked on resident #002 at the beginning of their shift, but had not checked on resident #002 the remainder of the shift.

Review of the home’s investigative notes noted a letter to PSW #107 which stated PSW #107’s behaviour was in violation of the home’s policy on Resident Abuse and Neglect.

In an interview, the Director of Care (DOC) stated after their investigation they found PSW #107 had neglected to provide continence care to resident #002 during their shift.

Sources:
Review of a CIS report, resident #002’s clinical records, the home’s investigative records, the home’s “Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff” policy with a review date of September 2018; and interviews with the DOC, PSW #103, PSW #104 and PSW #107. [s. 19. (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 residents are free from neglect, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care by the home related to allegations that residents #002, #003 and #004 did not receive continence care during a specific shift.

Review of the home's "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy noted in part that for allegations of resident abuse and neglect that the Director of Care (DOC) or Charge Nurse would complete and document a Head to Toe assessment of the resident.

Review of resident #002, #003 and #004's clinical records in Point Click Care (PCC) noted the absence of a head to toe assessment of resident #002, #003 and #004 after allegations that the residents did not receive continence care on a specific shift.

In an interview, the DOC acknowledged registered staff should have completed a head to toe assessment of residents #002, #003 and #004 to determine if the residents had developed any altered skin integrity after allegations that residents #002, #003 and #004 had not received proper continence care.

Sources:
Review of a CIS report, resident #002, #003 and #004's clinical records, the home's "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy with a review date of September 2018; and interviews with the DOC, Personal Support Worker (PSW) #103 and #104. [s. 20. (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 the home's policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 29th day of November, 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) :	JULIE LAMPMAN (522)
Inspection No. / No de l’inspection :	2021_725522_0013
Log No. / No de registre :	010855-21, 015350-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 26, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	The Maples Home for Seniors 94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Joan Hergott

To Caressant-Care Nursing and Retirement Homes Limited, 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 :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically,
A) Complete and document hand hygiene and Personal Protective Equipment (PPE) training with Screener #105;
B) Ensure registered staff are wearing full PPE when performing surveillance testing;
C) Ensure active screening questions are asked as per the Ministry of Health COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective July 14, 2021 or as current, for all persons entering the home.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) Review of the home's "Job Tasks – COVID-19 Door Screener" policy noted in part, that Screener's were to don Personal Protective Equipment (PPE) including a gown, mask, shield and gloves; unless behind plexiglass; in which case they required a mask only.

On a specific date, Inspector #522 was let into a small foyer by Screener #105 who was only wearing a face mask. There was no plexiglass barrier between Screener #105 and the inspector.

The following day, Inspector #522 was screened by the Director of Care (DOC) who was wearing a face mask and gown, but no eye protection. Inspector #522 also observed Screener #106 screen staff and visitors without eye protection.

In interviews, Screener #105 and Screener #106 both stated they did not wear eye protection while they completed screening of staff and visitors. Screener #105 also stated at times when they were busy, they would forget to put on a gown.

In an interview, the DOC stated the screeners were expected to wear a gown and face mask.

B) Review of the home's "Donning and Doffing of Personal Protective Equipment" policy noted the following in part:

Staff were to always perform hand hygiene immediately before they donned and after they doffed their PPE.
When staff donned a gown, it was to be secured at the neck and waist.
When staff doffed a gown, the gown front and sleeves were considered dirty and staff were to turn the contaminated outside surface of the gown toward the inside and roll the gown into a bundle.

i) On a specific date, Inspector #522 observed Screener #105 on several occasions don and doff their PPE inappropriately.

In an interview, Screener #105 stated they did not know the proper way to don and doff a gown and acknowledged that they had not removed their mask properly when they took a drink.

ii) The following day, Inspector #522 was screened by the DOC who was wearing a gown that had not been tied.

In an interview, the DOC stated when staff wore a gown it should be tied at the neck and waist and staff should hand sanitize when they donned and doffed PPE and staff should remove their mask when they drank. The DOC stated if staff used a disposable gown it should be disposed of properly after use.

C) Review of the home's "Hand Hygiene" policy noted hand hygiene must be performed after removing PPE and after contact with a resident or items in their immediate surroundings and when leaving the resident even if the resident has not been touched.

i) On a specific date, Inspector #522 observed the Activity Director (AD) wheel a resident in a wheelchair into the resident's room. The AD left the resident's room and did not sanitize their hands.

In an interview, the AD acknowledged they had wheeled the resident into their room and did not sanitize their hands when they left the resident and they should have.

ii) On a specific date, observations of Screener #105 noted on numerous occasions the Screener did not sanitize their hands when they removed their gown and after they touched their mask.

In an interview, Screener #105 acknowledged they did not sanitize their hands when they removed their gown and pulled down their mask and were unsure of the process for hand hygiene when they removed their PPE.

In an interview, the DOC stated staff should hand sanitize when they donned and doffed PPE and when they left a resident's room after they portered a resident.

D) Review of the home's "COVID-19 Surveillance and Access to LTC Homes" policy noted when registered staff completed surveillance testing in the home, they were to wear PPE, including a gown, surgical mask, eye protection and gloves.

On a specific date, Inspector #522 observed Registered Nurse (RN) #102 perform a rapid antigen test on a contractor outside of the home. RN #102 was observed with only a face mask on.

In an interview, RN #102 stated they normally wore full PPE when they completed a rapid antigen test, but since they had performed the rapid antigen test on the contractor outside of the home they only wore a face mask and gloves.

In an interview, the DOC stated staff should always wear full PPE, including a gown, gloves, face mask and goggles, when they completed a rapid antigen

test.

E) Review of the home's "Management of COVID-19 – Staff Roles & Responsibilities" policy noted in part that the Personnel assigned to the entrance of the home would conduct active screening on all team members, volunteers, contractors, and visitors to the home as outlined by Public Health Units.

Review of Directive #3 for Long-Term Care Homes (LTCH) under the Long-Term Care Homes Act, 2007 noted anyone wishing to enter a LTCH must be actively screened prior to being permitted entry into the LTCH. Directive #3 stated LTCHs must following the COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes.

The Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes noted at a minimum, the following questions should be asked to screen individuals for COVID-19 before entry - if the person had any new or worsening symptoms of fever and/or chills, cough or barking cough (croup), shortness of breath, decrease or loss of smell or taste, fatigue. lethargy, malaise and/or myalgias.

On several occasions during the inspection, Screener #105 and Screener #106 were observed screening visitors and staff members. Screener #105 and Screener #106 did not ask all of the visitors and staff members if they had typical and atypical symptoms of COVID-19. The Screeners were observed asking only if the person had any symptoms.

In an interview, Screener #105 confirmed there was a list of typical and atypical symptoms of COVID-19 as part of their screening questions on their laptop.

In an interview, Screener #106 stated if they screened a visitor they would ask about the typical and atypical symptoms of COVID-19, but for staff they did not go through the whole question as staff knew them. Screener #106 stated it was too busy when staff were coming in to go through the whole question.

In an interview, the DOC stated the Screener's should ask about typical and atypical symptoms of COVID-19 when screening staff and visitors.

Not following the home's infection prevention and control (IPAC) policies put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources:

IPAC observations of the home, review of Directive #3 for Long-Term Care Homes (LTCH) under the Long-Term Care Homes Act, 2007, the Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes Version 6 – August 27, 2021, the home's "Job Tasks – COVID-19 Door Screener" policy dated August 6, 2021; the home's "Donning and Doffing of Personal Protective Equipment" with a review date of April, 2018, the home's "Hand Hygiene" policy reviewed/revised September 2020, the home's "COVID-19 Surveillance and Access to LTC Homes" policy reviewed/revised March 2021, and the home's "Management of COVID-19 – Staff Roles & Responsibilities" policy; interviews with Screener #105, Screener #106, RN #102, the Activity Director, the DOC and the Executive Director.

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

Severity: There was actual risk to residents as screeners were observed not wearing eye protection and a screener was observed doffing PPE inappropriately then going into the home to assist with residents, also persons entering the home were not always asked if they were experiencing specific symptoms of COVID-19.

Scope: This noncompliance was a pattern as screeners were observed not wearing eye protection, an RN was observed not wearing appropriate PPE while completing a rapid antigen test, a screener was observed doffing their PPE inappropriately and persons entering the home were not always asked if they were experiencing specific symptoms of COVID-19.

Compliance History: There was no previous noncompliance issued related to O. Reg. 79/10, s. 229 (4). (522)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2022

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 26th day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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