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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Dec 9, 2021	2021_946111_0006	003640-21, 005222-21, 006670-21, 017954-21	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 Peterborough ON K9J 6X6

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

Pleasant Meadow Manor
99 Alma Street P.O. Box 426 Norwood ON K0L 2V0

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

LYNDA BROWN (111)

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): November 8 to 10, 2021.

There were four critical incident (CI) inspections conducted concurrently during this inspection:
-two related to resident to resident abuse.
-one related to staff to resident neglect.
-one related to a reportable disease outbreak.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Clinical Care Coordinator (CCC), Maintenance, Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers (HSK) and residents.

During the course of the inspection , the inspector(s): toured the home, observed a meal service, reviewed resident health records, daily surveillance records, line listing, home's investigations, employee records, job routines, and the following policies: zero tolerance of abuse and neglect and infection, prevention and control (IPAC).

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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **4 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 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 :

The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff in the home.

Under O.Reg. 79/10, s.5 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 PSW discovered that a resident had sustained a fall and suspected had been neglected. The resident was upset and indicated they had attempted to call for assistance. Some staff confirmed they had not checked on the resident for the entire shift and another staff indicated they had observed the resident a number of hours before the resident was discovered, and no care had been provided. The home's action to prevent a recurrence included all staff involved would be re-training on their job duties and the Administrator/DOC confirmed no actions had been taken. Failing to provide the resident with appropriate safety checks and care, lead to the resident being neglected.

Sources: CIS, review of a resident's progress notes, interview of the resident, review of the home's investigation, job routines, and interview of staff.

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. 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 :

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A PSW discovered that a resident had sustained a fall and suspected had been neglected. The RN who was involved in the suspected neglect had initiated the investigation and confirmed that neglect had occurred. There was no documented evidence that the RN was interviewed or the staff member who discovered the resident, was interviewed as per the home's policy. The home’s process for conducting investigations, also included specified interview processes, an evaluation of the evidence to determine if concerns were substantiated, a report prepared to summarize the findings of the investigation and the utilization of a disciplinary report and/or re-instruction forms. The Administrator confirmed the suspected neglect was determined to be founded, they had not completed the required forms or interviews as per the home’s policy and no re-instruction or any other action was taken, to prevent a recurrence.

Sources: CIS, Zero Tolerance of Abuse and Neglect (Investigation Procedures) policy, the home’s investigation and interview of staff.

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that appropriate action was taken in response to an incident of suspected neglect of a resident.

A PSW discovered that a resident had sustained a fall and suspected had been neglected. The home's action to prevent a recurrence included all staff who were involved would receive re-training on their job duties. All of the staff involved confirmed that no re-training had been provided.The Administrator/DOC confirmed they took no actions related to a suspected neglect of a resident. Failing to take appropriate actions with suspected neglect of a resident can lead to further incidents of neglect.

Sources: CIS, review of a resident's progress notes, interview of the resident, review of the home's investigation and job routines, and interview of staff.[s. 23. (1) (b)]

2. The licensee has failed to ensure that the results of the neglect investigation involving a resident was reported to the Director.

For the same incident identified above, there was no documented evidence that the results of the investigation were reported to the Director. The Administrator/DOC confirmed the results of the investigation were not reported to the Director.

Sources: CIS, review of resident's progress notes, review of the home's investigation and interview of staff. [s. 23. (2)]

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 a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (ii) neglect of a resident by the licensee or staff, (b) appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, in the home.

The home was declared in a reportable outbreak by Public Health, with three residents affected. The Director was notified of the outbreak the following day. The Administrator confirmed they did not immediately contact the Director regarding the outbreak.

Sources: CIS, Public Health line listing and interview of staff.

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 Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home: 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (7) The licensee shall implement any surveillance protocols given by the Director for a particular communicable disease. O. Reg. 79/10, s. 229 (7).

Findings/Faits saillants :

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

The home was declared by Public Health in an outbreak, with a number of residents affected. Two resident's were placed on specified isolation precautions. Both residents were in separate room, but in a shared room and their privacy curtain had not been drawn closed between their room mates, as required with evidenced-based practice (EBP). Failure to ensure their privacy curtains are drawn can place the room mates at additional risk of transmission of infections.

Sources: Control of Respiratory Infection Outbreaks in Long-Term Care Homes,

November 2018 (Ministry of Health and Long-Term Care) and observations. [s. 229 (4)]

2. The licensee has failed to ensure that staff on every shift recorded symptoms of infection for three resident's, and took immediate action as required.

A resident developed symptoms of infection on a specified day and shift, and there was no documentation of their monitoring of symptoms or to indicate that they were placed on isolation until the following shift. Three residents had all developed symptoms of infections and there were a number of shifts during their isolation that had no documented assessment of the residents. An RPN and the Administrator/DOC both confirmed the expectation was that Registered staff would monitor and record symptoms of infection in the residents progress notes on each shift, as well as place the residents on necessary isolation precautions. They both confirmed that the PHU was not informed of the suspected outbreak until two days later. Failing to record symptoms of infection on every shift and take immediate actions, may lead to inaccurate determination of onset of symptoms, symptoms may go undetected and residents may be left in isolation for longer than required.

Sources: CIS, progress notes for three residents, Public Health line listing and interview of staff. [s. 229. (5) (b)]

3. The licensee has failed to ensure that they implemented any surveillance protocols given by the Director for a particular communicable disease.

The home was required to have an ongoing surveillance program in place to determine the presence of infections, to identify sentinel events and trends and the ability of the infection control practitioner (ICP) to analyze the surveillance data in order to trigger actions such as notifying the Public Health (PH) as necessary. The two ICP leads indicated the daily surveillance of infections was to be recorded on a specified form and confirmed the form was not completed until the outbreak was declared by PH. Failing to implement their surveillance protocol led to a trend of infections in residents in the home that was not detected or reported to PH, until a number of days later.

Sources: CIS, progress notes for three residents, Public Health line listing, Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018 Ministry of Health and Long-Term Care November 2018, and interview of staff.[s. 229. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by another resident, that resulted in harm or risk of harm, had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A staff member had witnessed an incident of resident to resident abuse and the incident was not reported to the Director until the following day. The Administrator/DOC confirmed the Director was not immediately notified of the witnessed abuse.

Sources: CIS, progress notes of two residents and interview of staff.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

The licensee has failed to ensure that police record checks are conducted prior to hiring the staff member and/or accepted volunteer who is 18 years of age or older.

A PSW was directly involved in a resident neglect incident. There was no documented evidence to indicate the PSW had a police record check conducted prior to hiring. The Administrator confirmed they had no documented evidence to indicate the PSW had a police record check completed. Failing to complete a police record check could lead to the home not being aware of potential criminal charges against the employee that may place the residents at risk.

Sources: (CIS), employee records and interview of staff.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, 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. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

A PSW was directly involved in resident neglect incident. The PSW could not recall if they had received training on the home's zero tolerance of abuse policy and there was no documented evidence to indicate the PSW had received the training upon hire. Failing to ensure all new staff receive training on zero tolerance of abuse and neglect lead to an incident of abuse and neglect toward a resident.

Sources: (CIS), employee records and interview of staff.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident and the resident's SDM, were notified of the results of the alleged neglect investigation immediately upon the completion.

A resident had sustained a fall and had been neglected for a number of hours. The home's investigation had no documented evidence that the resident or the resident's SDM were notified of the results of the investigation. The resident indicated they were never told about the results of the investigation and wanted to know what the outcome was. The Administrator/DOC confirmed they had not informed the resident or the resident's SDM of the results of the investigation, upon its completion.

Sources: CIS, review of a resident progress notes, interview of the resident, review of the home's investigation and interview of staff.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any witnessed incident of neglect of a resident that the licensee suspects may constitute a criminal offence.

A resident had sustained a fall and had been neglected for a number of hours. There was no documented evidence that the police were notified of the incident. The Administrator/DOC confirmed the incident was considered neglect and the police were not notified.

Sources: CIS, review of a resident's progress notes, review of the home’s investigation and interview of staff.

Issued on this 13th day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l’inspection :	2021_946111_0006
Log No. / No de registre :	003640-21, 005222-21, 006670-21, 017954-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 9, 2021
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, Peterborough, ON, K9J-6X6
LTC Home / Foyer de SLD :	Pleasant Meadow Manor 99 Alma Street, P.O. Box 426, Norwood, ON, K0L-2V0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sandra Brow

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

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee is to be compliant with LTCHA, 2007, s.19(1).

Specifically, the licensee shall:
-Review and revise the nightly procedures to ensure they include that all residents are monitored at regular intervals throughout the night.
-Retrain all the night shift nursing staff on those revised procedures and keep a documented record of the re-training provided.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from neglect by the licensee or staff in the home.

Under O.Reg. 79/10, s.5 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 PSW discovered that a resident had sustained a fall and suspected had been neglected. The resident was upset and indicated they had attempted to call for assistance. Some staff confirmed they had not checked on the resident for the entire shift and another staff indicated they had observed the resident a number of hours before the resident was discovered, and no care had been provided. The home's action to prevent a recurrence included all staff involved would be re-training on their job duties and the Administrator/DOC confirmed no actions had been taken. Failing to provide the resident with appropriate safety checks and care, lead to the resident being neglected.

Sources: CIS, review of a resident's progress notes, interview of the resident, review of the home's investigation, job routines, and interview of staff.

The Compliance Order (CO) was issued by taking the following into account:
-The scope was isolated as only one resident was affected by the neglect.
-The severity was actual harm to the resident as the resident was left for a number of hours after sustaining a fall, with care not provided.
-There was no compliance history in the past three years related to LTCHA, 2007, s.19(1). (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 9th day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lynda Brown

Service Area Office /
Bureau régional de services : Central East Service Area Office