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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Amended Public Copy/Copie modifiée 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
May 10, 2021	2021_841679_0004 (A1) (Appeal\Dir#: DR# 150)	001721-21, 001769-21, 001776-21	Complaint

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 chemin Coursol Road Sturgeon Falls ON P2B 2Y6

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

The West Nipissing General Hospital
725 chemin Coursol Road Sturgeon Falls ON P2B 2Y6

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

Amended by Alain Plante (Director) - (A1)(Appeal\Dir#: DR# 150)

Amended Inspection Summary/Résumé de l'inspection modifié

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#002.
The Director's review was completed on May 10, 2021.
Order(s) CO#002 was/were rescinded to reflect the Director's review DR# 150.

Issued on this 10th day of May, 2021 (A1)(Appeal\Dir#: DR# 150)

[redacted]

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

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

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

Amended by Alain Plante (Director) - (A1)(Appeal/Dir# DR# 150)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 1-5 and 8-10, 2021.

The following intakes were inspected upon during this Complaint (CO) Inspection:

- Three intakes regarding staff members providing care to patients of the alternate level of care (ALC) unit.

A Critical Incident System (CIS) Inspection #2021_841679_0003 was conducted concurrently with this inspection.

A Compliance Order related to s. 5 of the Long-Term Care Home's Act, 2007, identified in concurrent inspection #2021_841679_0003, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Nurse Manager, Manager of Infection Prevention and Control, Human Resources (HR) Manager, Pharmacist, Behavioural Supports Ontario (BSO), Clinical Educator/Head Nurse, Staffing Officer, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Therapist, Housekeepers, COVID-19 screeners, residents and family members.

The Inspectors also conducted a daily tour of resident care areas, observed infection prevention and control (IPAC) practices, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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, with respect to COVID-19 screening required by Directive #3 for Long-Term Care Homes.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued December 7, 2020, indicated that long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19. Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks.

A Ministry of Health document titled "COVID-19 Guidance: Long-Term Care Homes" dated April 15, 2020, indicated that long-term care home's should have a screener at the entrance who was able to conduct screening during business hours and change of shift. Outside of these times, the home's charge nurse/administrator should develop processes and procedures to ensure that all persons entering the home are screened and visits are logged. These procedures are to be applied seven days a week and 24 hours a day.

a) Three staff members stated that they had entered the home via the "Doctor's door", had walked into the LTC home's unit wearing a mask from home and self-screened at the nurses' desk, prior to working. The staff stated this was the routine when there was no screener at the LTC home's entrance.

The Manager for Infection Prevention and Control (IPAC) stated that staff were to self-screen at home using a web based application prior to entering the home, and have their temperature taken when they entered the home by a registered staff on the LTC home unit, if there were no screeners at the LTC home's entrance. The Manager for IPAC stated that staff were to have their temperature taken by a registered staff and were not to take their own temperature.

Sources: Interview with Human Resources Manager, Manager for IPAC, and other staff; Inspector observations; Directive #3 for Long-Term Care Homes.

b) On one occasion, Inspector #679 entered the home through the emergency room entrance, as there was no screener present for the main entrance to the hospital/Long-Term Care unit. The Inspector was not asked questions related to

symptoms of COVID-19 prior to entering the long-term care home.

Sources: Inspector #679's observation; Interviews with COVID-19 screeners; Directive #3 for Long-Term Care Home's. [679]

c) Inspector #627 interviewed a patient from the transitional alternate level of care (TALC) unit, while they were in the activity room of the Long-Term Care (LTC) home. The patient stated that they often came to use the computer, or the TV room in the LTC home. They also left the unit, and the building for specified purposes. The patient stated that they were not screened when entering or leaving the LTC unit, or the TALC unit.

The Clinical Nurse Manager stated that patients in the TALC unit were not screened when they entered the LTC home unit.

Sources: Interview with a patient from TALC unit, COVID-19 screener and Clinical Nurse Manger; Observations; Directive#3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued December 7, 2020.

Visitors and staff should have only been permitted to enter the home after they had been screened in accordance with the guidelines outlined in Directive #3 for Long-Term Care Homes, and the Minister's Directive titled "COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes". Non-adherence to the screening requirements placed residents in the home at risk of disease transmission. [s. 5.]

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents related to limiting employee work locations in accordance with the required Infection Prevention and Control (IPAC) COVID-19 protocols.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, directed long-term care homes to have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness.

An order made under Ontario Regulation 146/20, subsection 7.0.2 (4) of the Emergency Management and Civil Protection Act, signed April 14, 2020, which was continued under the Reopening Act, 2020, stated: Beginning at 12:01 am on Wednesday, April 22, 2020, an employee of a long-term care provider who

performs work in a long-term care home operated or maintained by the long-term care provider shall not also perform work (a) in another long-term care home operated or maintained by the long-term care provider; (b) as an employee of any other health service provider; or (c) as an employee of a retirement home.

During separate interviews, three staff members stated that during a shift, they may work in more than one area of the hospital, including the hospital's medical unit, Complex Continuing Care Unit, Alternate Level of Care Unit and the Long-Term Care unit.

The Clinical Nurse Manager stated that they had not cohorted staff and that LTC home staff worked in other units of the hospital, and floated to other units of the hospital during their shift on the LTC unit, if there was a shortage of staff. The Clinical Nurse Manager indicated that staff from the LTC unit provided care to the patients in the TALC unit during evening and night shift, and other times when the patient required care. [s. 5.]

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. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that more beds were not operated in a long-term care home than was allowed under the license for the home.

Three complaints were submitted to the Director, regarding staff members having to provide care to the transitional alternate level of care (TALC) unit. A complainant stated that the home had opened a new TALC unit as part of the Long-Term Care (LTC) home, and that staff were expected to work with residents on both wings.

The Long-Term Care Home was licensed for 48 beds, with 44 beds occupied at the time of the inspection. Additionally, there were five patient beds occupied within the TALC unit at the time of the Inspection.

In separate interviews with three staff members, they stated that patients from the TALC unit were considered as part of the LTC unit. The patients from the TALC unit were bathed in the LTC home tub room, by LTC home staff and utilized the LTC home's TV room and activity room. There were no staff scheduled for the TALC unit on evening and nights as LTC home staff were responsible for providing care to the LTC home residents and TALC patients. PSWs were to assist the RPN during weekdays, and if there was no RPN scheduled in the TALC unit, the RPN from the LTC home would provide care to residents in the LTC home as well as patients in the TALC unit.

A review of the LTC home's floor plan showed the LTC home's unit and the TALC unit shared the same entrance; the hallway to the TALC unit was attached to the LTC home. The activity room was situated in the LTC home's unit. The LTC home had one tub room, which was shared between the LTC home residents and the TALC unit patients.

The Clinical Nurse Manager indicated that the TALC unit had five admitted patients, with a potential of six patients and that two beds would be created in the LTC home's activity room as they had been approved for eight TALC beds. The Clinical Nurse Manager further stated that there was no scheduled staff for the TALC unit on afternoon, and night shift, and the PSWs who work in the LTC home assumed care of the patients in the TALC unit. The afternoon RPN and PSWs assumed care of the patients in the TALC unit. They stated that part of the rational was that the LTC home was licensed for 48 beds but only 44 occupied beds at this time.

Sources: Interview with the Staffing Officer, Clinical Nurse Manager and other staff; Record review including: the LTC home and TALC unit floor plan, staff schedule for February 2021; three complaint intakes. [s. 104. (1)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 150)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to pursue religious, spiritual interests and to be given reasonable assistance by the licensee to pursue these interests was respected and promoted.

In separate interviews, two staff members stated that a resident's family requested a specified religious service. The requested was denied by the Manager for IPAC.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act,

2007, issued December 7, 2020, indicated that homes must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies. Directive #3 specified that an essential visitor was defined as including a person visiting a very ill or palliative resident and that essential visitors were the only type of visitors allowed when the long-term care home was located in a public health unit region where there was evidence of increasing/significant community transmission i.e., Orange (Restrict), Red (Control) or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open.

Additionally, a memo titled "Provincewide Shutdown to Stop Spread of COVID-19" issued on December 24, 2020, to Long-Term Care Home Steakholders indicated that a Province-wide shutdown was put in place effective on December 26, 2020, and that essential visitors were the only type of visitors permitted to visiting long-term care homes in Grey zones, as identified in the Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes, and Directive #3 for Long-Term Care Homes.

The home’s policy titled “CAREGIVER I am a caregiver (#100-148)", approved July 31, 2020, identified that a person may be present to provide spiritual or religious need to the resident as an essential visitor.

The Manager for IPAC stated that due to the provincial lock down, the home was not allowing any visitors in.

Sources: Interviews with two staff members and the Manager for IPAC; Record review: home’s policy titled “CAREGIVER I am a caregiver (#100-148)", approved July 31, 2020; Minister’s Directive, published November 22, 2020; Directive #3 for Long-Term Care Homes under Long-Term Care Homes Act,2007, issued December 7, 2020 and Memo titled "Provincewide Shutdown to Stop Spread of COVID-19" issued on December 24, 2020. [s. 3. (1) 23.]

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 ensuring that residents rights are fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Minister's Directive "COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes" was carried out.

The Minister's Directive "COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes", effective January 8, 2021, indicated that during a grey lockdown level, staff were to have a weekly polymerase chain reaction (PCR) test.

A staff member from the West Nipissing General Hospital stated that they were asked to come and assist in the LTC home during a night shift, although they had not been swabbed for COVID-19; they had assisted a resident with bathing and personal care.

The Manager for IPAC confirmed that the hospital worker had not received a PCR test prior to working in the LTC home.

Sources: Interview with staff member from West Nipissing General Hospital and the Manager for IPAC; Minister's Directive "COVID-19: Long- Term Care Home Surveillance Testing and Access to Homes", effective January 8, 2021. [s. 174.1 (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 ensuring that the licensee of the long-term care home carries out every operational or policy directive that applies to the long-term care home, to be implemented voluntarily.

Issued on this 10th day of May, 2021 (A1)(Appeal/Dir# DR# 150)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Alain Plante (Director) - (A1) (Appeal/Dir# DR# 150)
Inspection No. / No de l'inspection :	2021_841679_0004 (A1)(Appeal/Dir# DR# 150)
Appeal/Dir# / Appel/Dir#:	DR# 150 (A1)
Log No. / No de registre :	001721-21, 001769-21, 001776-21 (A1)(Appeal/Dir# DR# 150)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 10, 2021(A1)(Appeal/Dir# DR# 150)
Licensee / Titulaire de permis :	The West Nipissing General Hospital 725 chemin Coursol Road, Sturgeon Falls, ON, P2B-2Y6
LTC Home / Foyer de SLD :	The West Nipissing General Hospital 725 chemin Coursol Road, Sturgeon Falls, ON, P2B-2Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cynthia Desormiers

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 The West Nipissing General Hospital, 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. 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.

Order / Ordre :

The licensee must be compliant with s. 5. of the Long-Term Care Home's Act, 2007.

Specifically, the licensee shall:
a) Ensure that all staff, visitors and any anyone else entering the long-term care home are screened in accordance with the requirements set out in Directive #3 for Long-Term Care Homes; and,

b) Ensure that to the extent possible, staff and resident's are cohorted as part of the home's approach to preparedness as set out in Directive #3 for Long-Term Care Homes.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, with respect to COVID-19 screening required by Directive #3 for Long-Term Care Homes.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued December 7, 2020, indicated that long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19. Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks.

A Ministry of Health document titled "COVID-19 Guidance: Long-Term Care Homes" dated April 15, 2020, indicated that long-term care home's should have a screener at

the entrance who was able to conduct screening during business hours and change of shift. Outside of these times, the home's charge nurse/administrator should develop processes and procedures to ensure that all persons entering the home are screened and visits are logged. These procedures are to be applied seven days a week and 24 hours a day.

a) Three staff members stated that they had entered the home via the "Doctor's door", had walked into the LTC home's unit wearing a mask from home and self-screened at the nurses' desk, prior to working. The staff stated this was the routine when there was no screener at the LTC home's entrance.

The Manager for Infection Prevention and Control (IPAC) stated that staff were to self-screen at home using a web based application prior to entering the home, and have their temperature taken when they entered the home by a registered staff on the LTC home unit, if there were no screeners at the LTC home's entrance. The Manager for IPAC stated that staff were to have their temperature taken by a registered staff and were not to take their own temperature.

Sources: Interview with Human Resources Manager, Manager for IPAC, and other staff; Inspector observations; Directive #3 for Long-Term Care Homes.

b) On one occasion, Inspector #679 entered the home through the emergency room entrance, as there was no screener present for the main entrance to the hospital/Long-Term Care unit. The Inspector was not asked questions related to symptoms of COVID-19 prior to entering the long-term care home.

Sources: Inspector #679's observation; Interviews with COVID-19 screeners; Directive #3 for Long-Term Care Home's. [679]

c) Inspector #627 interviewed a patient from the transitional alternate level of care (TALC) unit, while they were in the activity room of the Long-Term Care (LTC) home. The patient stated that they often came to use the computer, or the TV room in the LTC home. They also left the unit, and the building for specified purposes. The patient stated that they were not screened when entering or leaving the LTC unit, or the TALC unit.

The Clinical Nurse Manager stated that patients in the TALC unit were not screened

when they entered the LTC home unit.

Sources: Interview with a patient from TALC unit, COVID-19 screener and Clinical Nurse Manger; Observations; Directive#3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued December 7, 2020.

Visitors and staff should have only been permitted to enter the home after they had been screened in accordance with the guidelines outlined in Directive #3 for Long-Term Care Homes, and the Minister's Directive titled "COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes". Non-adherence to the screening requirements placed residents in the home at risk of disease transmission. (627)

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents related to limiting employee work locations in accordance with the required Infection Prevention and Control (IPAC) COVID-19 protocols.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, directed long-term care homes to have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness.

An order made under Ontario Regulation 146/20, subsection 7.0.2 (4) of the Emergency Management and Civil Protection Act, signed April 14, 2020, which was continued under the Reopening Act, 2020, stated: Beginning at 12:01 am on Wednesday, April 22, 2020, an employee of a long-term care provider who performs work in a long-term care home operated or maintained by the long-term care provider shall not also perform work (a) in another long-term care home operated or maintained by the long-term care provider; (b) as an employee of any other health service provider; or (c) as an employee of a retirement home.

During separate interviews, three staff members stated that during a shift, they may work in more than one area of the hospital, including the hospital's medical unit, Complex Continuing Care Unit, Alternate Level of Care Unit and the Long-Term Care unit.

The Clinical Nurse Manager stated that they had not cohorted staff and that LTC home staff worked in other units of the hospital, and floated to other units of the hospital during their shift on the LTC unit, if there was a shortage of staff. The Clinical

Nurse Manager indicated that staff from the LTC unit provided care to the patients in the TALC unit during evening and night shift, and other times when the patient required care.

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

Severity: Actual risk was identified in the home related to COVID-19 screening practices and staff cohorting/limiting employee work locations.

Scope: The scope of this non-compliance was widespread because of the number of identified concerns related to ensuring a safe and secure environment for its residents.

Compliance History: One Compliance Order (CO) which had been complied, two Voluntary Plans of Correction (VPCs) and three Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 06, 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

(A1)(Appeal/Dir# DR# 150)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 002

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 104. (1) A licensee shall not operate more beds in a long-term care home than are allowed under the licence for the home or under the terms of a temporary licence issued under section 111 or a temporary emergency licence issued under section 112.

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

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:

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
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 10th day of May, 2021 (A1)(Appeal/Dir# DR# 150)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Alain Plante (Director) - (A1)
(Appeal/Dir# DR# 150)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

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