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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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 04, 2021	2021_661683_0003 (A1)	021719-20, 021720-20, 022048-20, 003487-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St Catherines ON L2S 1S9

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Home has requested an extension to the CDD to allow for DOC onboarding and staff training. New CDD May 31, 2021.

Issued on this 4 th day of May, 2021 (A1)

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*

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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 04, 2021	2021_661683_0003 (A1)	021719-20, 021720-20, 022048-20, 003487-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St Catherines ON L2S 1S9

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

Amended by LISA BOS (683) - (A1)

Amended 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): February 16, 17, 18, 19, 22, 23, 25, 26, March 1, 2, 3, 4, 5, 8, 10, 11, 12, 15 and 16, 2021.

This inspection was completed concurrently with complaint inspection #2021_661683_0004.

The following intakes were completed during this critical incident inspection:

Log #022048-20, CIS #1500-000041-20 was related to the prevention of abuse and neglect; and

Log #003487-21, CIS #1500-000005-21 was related to responsive behaviours and the prevention of abuse and neglect.

Additionally, two follow up inspections were completed concurrently with this critical incident inspection:

Log #021719-20 was related to CO #001 from inspection #2020_820130_0014 regarding LTCHA, s. 6 (11); and

Log #021720-20 was related to CO #002 from inspection #2020_820130_0014 regarding LTCHA s. 6 (7).

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Dietary / Environmental Manager, Nursing Clerk, Recreation Manager, Registered Dietitian (RD), cooks, program aides, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support

Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) observed the provision of care, resident and staff interactions, infection prevention and control practices and reviewed clinical health records, relevant home policies and procedures, training records, internal investigation notes and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2020_820130_0014	683

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's fall prevention interventions were in place as per their plan of care.

A resident's written plan of care indicated that that they were at a risk for falls and they had several interventions in place to try and prevent falls. The resident was observed and four of their fall prevention interventions were not in place as per their plan of care, as confirmed by a Registered Practical Nurse (RPN).

A resident was at a risk of falls and four of their fall prevention interventions were not in place as per their plan of care, which put them at risk of injury if they were to fall.

Sources: A resident's clinical record; observations; interview with a RPN. [s. 6. (7)]

2. The licensee has failed to ensure that a resident's plan of care was revised when a fall prevention intervention was no longer necessary.

A resident's written plan of care indicated that they were at risk for falls. Their care plan directed staff to check that a fall prevention intervention was in place. The resident was observed, and the fall prevention intervention was not in place.

A RPN indicated that the resident no longer required the fall prevention intervention because they had a different intervention instead and acknowledged that the resident's plan of care was not revised when the intervention was no longer necessary.

Sources: A resident's clinical record; observations; interview with a RPN. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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) The home's Contact Precautions and Droplet Precautions policies identified that the appropriate signage was to be placed at the resident's room doorway to advise visitors to speak with a nurse before entering the room.

i) A tour of the home identified three resident rooms with signage for contact and droplet precautions, as confirmed by a Personal Support Worker (PSW). A review of the clinical record for the residents who resided in the respective rooms indicated that they required contact precautions only. The Director of Care (DOC) acknowledged that there was incorrect signage at the doorway of the identified resident rooms.

ii) A resident newsletter was observed outside a resident room covering contact and droplet precaution signage. A RPN indicated that a resident who resided in the room required contact precautions only, and that the signage was incorrect. The Executive Director confirmed that the signage should not have been covered with a resident newsletter.

iii) Two resident rooms were observed to have Personal Protective Equipment (PPE) present at the doorway but no signage to support additional precautions

were in use. The clinical records of the residents who resided in the rooms indicated that they required contact precautions. A Registered Nurse (RN) acknowledged that the rooms should have signage in place to support the use of additional precautions during the provision of care for the residents.

iv) Inspector #683 went to interview a resident and staff indicated that the resident was residing in the home's "isolation" room. The Inspector went to the "isolation" room and there was no signage on the door to indicate that it was an isolation room or that contact or droplet precautions were required, and there was no PPE available outside the door to the room. The DOC acknowledged that the resident was on contact precautions and there should have been signage and PPE available outside the room.

Lack of appropriate signage outside resident rooms put the residents and staff at risk of spreading infection.

Sources: Contact Precautions policy; Droplet Precautions policy; observations of signage and PPE; interview with the DOC, a RPN, RN and other staff.

B) The home's PPE policy directed staff to comply with the use of PPE if it was determined to be necessary by the home and/or the Public Health Authority, which included adhering to PPE donning and doffing principles when providing care for residents.

The home's Contact Precautions policy indicated that contact precautions were to be used by all care staff to provide care to a resident who had an infection that could be transmitted through direct or indirect contact which included the use of gloves and gowns.

A resident’s clinical record indicated that they required contact precautions.

Two PSWs were observed providing personal care to the resident and they were observed wearing gloves, but they did not wear a gown, despite appropriate signage and PPE available outside the resident's room. A RPN confirmed that the resident required contact precautions and the PSWs should have worn a gown and gloves while providing care to the resident.

By not wearing appropriate PPE, the PSWs put other residents at risk due to the possible spread of infection.

Sources: Observations of signage and PPE; a resident's clinical record; Personal Protective Equipment policy; Contact Precautions policy; interview with a RPN and other staff.

C) A resident required contact precautions and was assigned specific equipment and spaces for their own use. One of the spaces that was assigned to the resident was observed and there was no signage on the door to indicate that additional precautions were required nor was the door locked to prevent other residents from entering.

Lack of appropriate signage outside the resident's assigned private space put other residents at risk of entering the area and contracting the infection.

Sources: A resident's clinical record; observations and interview with the DOC. [s. 229. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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 a resident was protected from physical abuse by a co-resident.

LTCHA s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

There was an altercation between two residents and in response to the altercation, one resident demonstrated a physical behaviour towards the other, which resulted in an injury. A RPN indicated that upon their assessment, they believed the injury was caused by the one resident to the other.

There was minimal harm to the resident as a result of the physical altercation.

Sources: CI report; resident's clinical records; interview with a RPN and other staff. [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 that residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 4 th day of May, 2021 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA BOS (683) - (A1)
Inspection No. / No de l'inspection :	2021_661683_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021719-20, 021720-20, 022048-20, 003487-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 04, 2021(A1)
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	West Park Health Centre 103 Pelham Road, St Catherines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dan Semenuk

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 CVH (No. 1) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2020_820130_0014, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

1. Ensure that an identified resident's fall prevention interventions are in place as per their plan of care.
2. Perform weekly audits on an identified resident to ensure that their fall prevention interventions are in place as per their plan of care.
3. Document the audit, who completed it, date it was completed, outcome and any corrective actions taken.

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

Grounds / Motifs :

1. Compliance order #002 related to LTCHA, s. 6 (7) from inspection #2020_820130_0014 issued on October 27, 2020, with a compliance due date of November 23, 2020, is being re-issued as follows:

The licensee has failed to ensure that a resident's fall prevention interventions were in place as per their plan of care.

A resident's written plan of care indicated that that they were at a risk for falls and they had several interventions in place to try and prevent falls. The resident was observed and four of their fall prevention interventions were not in place as per their plan of care, as confirmed by a Registered Practical Nurse (RPN).

A resident was at a risk of falls and four of their fall prevention interventions were not in place as per their plan of care, which put them at risk of injury if they were to fall.

Sources: A resident's clinical record; observations; interview with a RPN.

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

Severity: There was minimal risk of harm because the resident was more likely to fall, or be injured from a fall, when their fall prevention interventions were not in place as per their plan of care.

Scope: This was an isolated case as the other residents reviewed during this inspection had their fall prevention interventions in place as per their plans of care.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with LTCHA, s. 6 (7). This subsection was issued as a CO on October 27, 2020, during inspection #2020_820130_0014 with a compliance due date of November 23, 2020. In the past 36 months, six other COs were issued to different sections of the legislation, all of which have been complied. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 comply with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that there is appropriate signage at the doorway of the rooms for the identified residents.
2. Ensure that staff wear appropriate PPE during the provision of care for an identified resident.
3. Re-train the identified staff on the home's Contact Precautions policy.
4. Document the education, including the date and the staff member who provided the education.
5. Designate one staff member to complete weekly audits throughout the entire home to ensure that appropriate signage is posted outside of all resident rooms who require additional precautions.
6. The identified staff member is to observe, at a minimum, the provision of care for one resident a week to ensure that staff don and doff their PPE correctly.
7. Document the audit, who completed it, the date it was completed, outcome and any corrective action taken.

Grounds / Motifs :

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

A) The home's Contact Precautions and Droplet Precautions policies identified that the appropriate signage was to be placed at the resident's room doorway to advise

visitors to speak with a nurse before entering the room.

i) A tour of the home identified three resident rooms with signage for contact and droplet precautions, as confirmed by a Personal Support Worker (PSW). A review of the clinical record for the residents who resided in the respective rooms indicated that they required contact precautions only. The Director of Care (DOC) acknowledged that there was incorrect signage at the doorway of the identified resident rooms.

ii) A resident newsletter was observed outside a resident room covering contact and droplet precaution signage. A RPN indicated that a resident who resided in the room required contact precautions only, and that the signage was incorrect. The Executive Director confirmed that the signage should not have been covered with a resident newsletter.

iii) Two resident rooms were observed to have Personal Protective Equipment (PPE) present at the doorway but no signage to support additional precautions were in use. The clinical records of the residents who resided in the rooms indicated that they required contact precautions. A Registered Nurse (RN) acknowledged that the rooms should have signage in place to support the use of additional precautions during the provision of care for the residents.

iv) Inspector #683 went to interview a resident and staff indicated that the resident was residing in the home's "isolation" room. The Inspector went to the "isolation" room and there was no signage on the door to indicate that it was an isolation room or that contact or droplet precautions were required, and there was no PPE available outside the door to the room. The DOC acknowledged that the resident was on contact precautions and there should have been signage and PPE available outside the room.

Lack of appropriate signage outside resident rooms put the residents and staff at risk of spreading infection.

Sources: Contact Precautions policy; Droplet Precautions policy; observations of signage and PPE; interview with the DOC, a RPN, RN and other staff.

B) The home's PPE policy directed staff to comply with the use of PPE if it was

determined to be necessary by the home and/or the Public Health Authority, which included adhering to PPE donning and doffing principles when providing care for residents.

The home's Contact Precautions policy indicated that contact precautions were to be used by all care staff to provide care to a resident who had an infection that could be transmitted through direct or indirect contact which included the use of gloves and gowns.

A resident's clinical record indicated that they required contact precautions.

Two PSWs were observed providing personal care to the resident and they were observed wearing gloves, but they did not wear a gown, despite appropriate signage and PPE available outside the resident's room. A RPN confirmed that the resident required contact precautions and the PSWs should have worn a gown and gloves while providing care to the resident.

By not wearing appropriate PPE, the PSWs put other residents at risk due to the possible spread of infection.

Sources: Observations of signage and PPE; a resident's clinical record; Personal Protective Equipment policy; Contact Precautions policy; interview with a RPN and other staff.

C) A resident required contact precautions and was assigned specific equipment and spaces for their own use. One of the spaces that was assigned to the resident was observed and there was no signage on the door to indicate that additional precautions were required nor was the door locked to prevent other residents from entering.

Lack of appropriate signage outside the resident's assigned private space put other residents at risk of entering the area and contracting the infection.

Sources: A resident's clinical record; observations and interview with the DOC.

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

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

Severity: There was minimal risk of harm because a lack of appropriate signage and PPE in place put other residents at risk of contracting an infection.

Scope: The scope was widespread because non-compliance was identified with several residents on both of the home's two floors.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10, s. 229 (4) and a Voluntary Plan of Correction (VPC) was issued to the home. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 31, 2021(A1)

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.

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

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 4 th day of May, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LISA BOS (683) - (A1)

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

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