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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 2, 2021	2021_861194_0002	003954-21, 004207-21, 004583-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

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

CHANTAL LAFRENIERE (194), 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): April 28, 29, May 3 and 4, 2021

The inspection included;
Log # 003954-21, related to a missing drug.
Log # 004207-21, related to a resident fall.
Log # 004583-21, related to an outbreak.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Physio Therapy Aide (PTA), Quality Aide/Screener, Housekeeper, Program Aide, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

During the course of the inspection the inspectors observed Infection Control practices, dining service, medication administration and provision of staff to resident care. The inspectors reviewed identified residents clinical health records, COVID-19 screening and testing records, relevant policies for infection control, medication administration and falls.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Pain
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control (IPAC) program was evaluated and updated at least annually, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices related to Personal Protective Equipment (PPE) use.

The licensee's IPAC policy "COVID-19 Universal Personal Protective Equipment (PPE) Guidelines" directed care staff to not doff mask and eye protection, unless visibly soiled, when providing care to residents with respiratory symptoms or confirmed positive with COVID-19. The DOC confirmed that staff providing care to resident's under droplet and contact precautions would not be required to change their mask and clean their eye protection unless soiled as per their policy. Evidence Best Practice (EBP) directs that a mask and eye protection worn by staff during droplet and contact precautions are to be removed, cleaned and disinfected after caring for the resident or leaving the residents dedicated environment. Failing to evaluate and update the IPAC program based on evidence-based practice, places staff and residents at an increased risk of transmission of infections.

Sources: COVID-19 Universal PPE Guidelines, Appendix 1 (dated April 2020), MOHLTC-Control of Respiratory Infection Outbreaks in Long Term Care Homes (November 2018) and interview of the DOC. [s. 229. (2) (d)]

2. The licensee failed to ensure that staff participated in the implementation of the Infection, Prevention and Control Program (IPAC).

The following IPAC concerns were identified by Inspector #194 in the home:

A resident room had a contact precaution sign with no direction related to what PPE to use. An RPN confirmed the resident was on contact precautions. A few days later, the same resident had signage indicating contact and droplet precautions. The DOC confirmed that the staff had posted the incorrect precautions signage. The DOC replaced the incorrect signage and posted the correct contact precautions sign that directed staff for PPE.

Two residents were identified as requiring droplet and contact precautions with no signage noted on the resident's doors. A PSW confirmed that they had assisted the resident with morning care. The PSW confirmed that they had not put on a gown and had not removed their mask or goggles after care. An RN confirmed that they had assisted the residents with specific equipment, stating they used an N95 mask, gloves and eye protection, but no gown. The RN confirmed that the resident was not under contact and droplet precautions and that they did not removed the mask or clean their eye protection after assisting the resident.

A PSW was observed providing residents their lunch meal in their room without offering the residents assistance with hand hygiene before or after their meal. Another staff member was observed providing residents their lunch meal in their room without offering the residents assistance with hand hygiene before or after their meal.

A resident was on isolation with contact and droplet precautions and the DOC confirmed the resident was symptomatic. A PTA was observed exiting the residents room without removing their mask or cleaning their eye protection. Two residents were on isolation with contact and droplet precautions, two staff were observed exiting the resident’s room without removing their mask or cleaning their eye protection. Failing to ensure that staff post appropriate signage, put on and remove PPE correctly and offer residents, hand hygiene before and after meals, increases the risk of transmission of infections to residents and staff.

Sources: Observations throughout the home and a lunch meal, review of progress notes for residents, COVID-19 Universal PPE Guidelines, dated April 2020 and interviews with staff. [s. 229. (4)]

3. The licensee failed to ensure that staff monitored symptoms of infection for residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The DOC indicated that residents with symptoms of infection were to be monitored every shift.

Two symptomatic residents were placed on isolation with contact and droplet precautions for four days. Two other symptomatic resident were placed on isolation with contact and droplet precautions for three days.The resident's symptoms were not monitored every shift.

Source: Infection Prevention and Control Guide PIDAC, Infection Surveillance policy #IC-03-01-01 dated October 2018, Daily 24-hour surveillance form, Progress notes for residents and staff interviews [s. 229. (5) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the IPAC program is updated at least annually, that staff monitored symptoms of infection in residents on every shift in accordance with evidence based practice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was easily accessed and used by a resident at all times.

At various times, a resident was observed by Inspector #111 sitting in a chair and the call bell remained clipped to their bed which was approximately six feet away. The call bell did not reach the resident. An RPN confirmed the resident was a high risk for falls and had fallen out of their chair. The RPN confirmed that the call bell did not reach the resident when they are sitting their chair. Failing to provide a resident to staff communication system when they are in their room at all times, places the resident at risk for falls and the staff the inability to hear them calling for assistance.

Sources: observations of resident, care plan of resident and interview of staff . [s. 17. (1) (a)]

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 By ensuring that the resident-staff communication response system is easily accessed and used by residents, to be implemented voluntarily.

WN #3: 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 failed to ensure that the home was safe and secure environment for residents, related to Directive #3's isolation precautions and active screening of residents.

Two fully immunized, asymptomatic residents returned to the home with a negative Polymerase Chain Reaction (PCR) test and were placed in isolation with droplet and contact precautions. Directive #3 was revised and indicated newly admitted residents and residents returning from hospital, who were asymptomatic, fully immunized against COVID-19 and had a negative PCR test, did not have to remain on 14-day quarantine isolation. The residents were kept in isolation for six to seven days after the Directive was in effect. Placing residents on isolation unnecessarily potentially decreases their well being.

The Director of Care (DOC) indicated residents were actively screened for COVID-19 symptoms by having their temperatures checked twice daily and any COVID-19 any symptoms identified were indicated on the home's 24-hour surveillance record for infections. The DOC indicated an Infection Prevention and Control (IPAC) COVID-19 assessment was also completed electronically in the resident's progress notes but was only completed for those residents on isolation. An RN also confirmed that the COVID-19 active screening documentation in the resident's progress notes would only be completed for symptomatic residents.

Resident temperature records for a two month period indicated that twenty residents were missing one of the temperature checks.

The DOC confirmed there was only active screening for COVID-19 symptoms completed on residents in isolation and the other resident had passive screening completed. Review of residents on isolation also demonstrated that they had not had active screening completed as follows:

A symptomatic resident was placed on isolation precautions and the active screening for COVID-19 was only completed once daily for a four day period. Four symptomatic residents were placed on isolation precautions and there was no active screening for COVID-19 completed. Two resident room-mates did not have active screening for COVID-19 completed. A resident returned to the home and was placed on isolation precautions and the active screening for COVID-19 was only completed once daily for eleven days. The resident was removed from isolation and later became symptomatic and was not placed in isolation and there was no active screening for COVID-19 completed.

Sources: observation of residents Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (updated April 23, 2021), Daily 24-hour symptom surveillance, Resident on Isolation form, Temperature twice daily form, laboratory results, progress notes for residents, Resident Infection Control Report, IPAC COVID-19 assessments and staff interviews. [s. 5.]

2. . [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the home is a safe and secure environment for residents, related to Directive #3, to be implemented voluntarily.

WN #4: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident was being reassessed for falls, and the plan of care was being revised, because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care for a resident.

A resident sustained a fall with injury and fall interventions were implemented. The resident sustained further falls with no injuries and staff recommended changing one of the falls interventions, but it was not implemented. Inspector #111 observed the resident sitting in their chair where the call bell was not accessible. A PSW confirmed that one of the falls interventions was not effective. RPN (falls lead) was not aware of the recommendation to change one of the falls interventions and indicated that the call bell did not reach the resident when they sat in their chair. Failing to consider different approaches when the care set out in the plan has been ineffective, can lead to further falls and possible injuries.

Sources: CIR, progress notes, post fall assessments and care plan of resident, observations of resident and interview of staff. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance By ensuring that when a resident is being reassessed for falls, the plan of care is revised, when the care set out in the plan is not effective, different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy, instituted or otherwise put in place was complied with related to medication use.

A resident was prescribed medication that required two registered nurses to sign when the medication was destroyed. The RN was to waste the remainder of medication that was not administered. The RN confirmed they had not documented one of the administered doses on the resident's electronic medication administration record (eMAR), had not correctly documented on the resident's individual medication count sheet of the amounts administered, the amounts to be wasted, to indicate that they had dropped medication on the floor and that they had forgotten to have the wasted medication witnessed by the oncoming shift as per the home's policy. Failing to comply with the home's medication policy results in increased risk to residents for medication incidents and unaccounted medications.

Sources: physician orders, progress notes and medication incident for resident, Medication policy (RC-16-01-13) updated March 2020 policy and interview of staff. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all drugs were stored in an area or a medication cart, that was secure and locked.

Inspector #194 observed an RPN's medication cart left unattended and unlocked near resident rooms. Inspector #111 observed an RN administering medication in a resident room. The inspector then observed that their medication cart had been left unlocked and unattended outside a resident room and a resident was sitting in a chair beside the medication cart. Failing to ensure a medication cart is kept secure and locked prevents possible missing medications and resident safety.

Sources: observations and interview of staff (RPN #112). [s. 129. (1) (a)]

2. The licensee has failed to ensure that specified medications are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

An RN had placed medication in the top drawer of the locked medication cart that was not double-locked. The medication was placed there to be witnessed to be destroyed by the oncoming shift. Failing to store medication in a separate locked area within the medication cart increases the risk for misappropriation of the medication.

Sources: medication incident for resident, observation of medication cart and interview of staff . [s. 129. (1) (b)]

Issued on this 3rd day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Order(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 sions de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2021_861194_0002
Log No. / Registre no:	003954-21, 004207-21, 004583-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 2, 2021
Licensee / Titulaire de permis :	CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Warkworth Place 97 Mill Street, P.O. Box 68, Warkworth, ON, K0K-3K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Allanson

To CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must do the following:

1.Place appropriate IPAC/PPE/Precautionary signage at the resident doorway, for any resident upon admission or readmission from hospital, according to PH guidelines.
2. Staff must don and doff appropriate PPE for any residents on isolation precautions.
3. Staff must assist resident with hand hygiene prior to and after meals.

Grounds / Motifs :

1. The licensee failed to ensure that staff participated in the implementation of the Infection, Prevention and Control Program (IPAC).

The following IPAC concerns were identified by Inspector #194 in the home:

A resident room had a contact precaution sign with no direction related to what PPE to use. An RPN confirmed the resident was on contact precautions. A few days later, the same resident had signage indicating contact and droplet precautions. The DOC confirmed that the staff had posted the incorrect precautions signage. The DOC replaced the incorrect signage and posted the correct contact precautions sign that directed staff for PPE.

Two residents were identified as requiring droplet and contact precautions with no signage noted on the resident's doors. A PSW confirmed that they had assisted the resident with morning care. The PSW confirmed that they had not

donned a gown and had not doffed their mask or goggles after care. An RN confirmed that they had assisted the residents with specific equipment, stating they used an N95 mask, gloves and eye protection, but no gown. The RN confirmed that the resident was not under contact and droplet precautions and that they did not doff the mask or clean their eye protection after assisting the resident.

A PSW was observed providing residents their lunch meal in their room without offering the residents assistance with hand hygiene before or after their meal. Another staff member was observed providing residents their lunch meal in their room without offering the residents assistance with hand hygiene before or after their meal.

A resident was on isolation with contact and droplet precautions and the DOC confirmed the resident was symptomatic. A PTA was observed exiting the residents room without doffing their mask or cleaning their eye protection. Two residents were on isolation with contact and droplet precautions, two staff were observed exiting the resident’s room without doffing their mask or cleaning their eye protection. Failing to ensure that staff post appropriate signage, don and doff PPE correctly and offer residents, hand hygiene before and after meals, increases the risk of transmission of infections to residents and staff.

Sources: Observations throughout the home and a lunch meal, review of progress notes for residents, COVID-19 Universal PPE Guidelines, dated April 2020 and interviews with staff. [s. 229. (4)]

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

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations on all units, and the non compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Voluntary Plan of Correction (VPC) was issued to O. Reg 79/10, s. 229(4) on October 31, 2020

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail 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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of June, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Chantal Lafreniere

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