Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 29, 2021	2021_556168_0003	004188-20, 022641-20, 025037-20, 025375-20	Critical Incident System

Licensee/Titulaire de permis

Grace Villa Limited
284 Central Avenue London ON N6B 2C8

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

Grace Villa Nursing Home
45 Lockton Crescent Hamilton ON L8V 4V5

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

LISA VINK (168)

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): January 28, 2021, February 1, 2, 4, 5, 8, 9, 10, 11, 12, 17, 18, 2021 and March 8, 9 and 10, 2021 onsite and on February 16, 22, 23, 24, 25 and 26, 2021 and March 1, 2, 3, 4 and 5, 2021 off-site.

This inspection was completed with registered nursing student Olive Mameza Nenzeko in attendance.

This inspection was completed with concurrent complaint inspection 2021_556168_0002.

This inspection was completed related to the following intakes:
004188-20 - for Critical Incident System (CIS) 2741-000006-20 for prevention of abuse and neglect;
022641-20 - for CIS 2741-000014-20 for falls prevention and management;
025037-20 - for CIS 2741-000018-20 for policies etc. to be followed; and
025375-20 - for CIS 2741-000019-20 for falls prevention and management.

Please note: Findings of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (4) a and 6 (10) b both related to plan of care were identified in this inspection and have been issued in complaint Inspection Report 2021_556168_0002, which was conducted concurrently with this inspection.
Findings of non-compliance related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b related to policies, etc. to be followed and s. 30 (1) (2) related to general requirements and s. 229 (5) related to infection prevention and control were identified in this inspection and have been issued in complaint Inspection Report 2021_556168_0002, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the former acting Director of Care (DOC), the current DOC, the assistant DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), pharmacy staff, Personal Support Workers (PSW), the Physiotherapist and residents.

During the course of the inspection, the inspector observed the provision of care and services, toured the home, reviewed records including but not limited to: clinical health records, policies and procedures, risk management records, training records, complaint records and program evaluations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that all residents were protected from abuse.

According to the clinical record resident #012 was involved in an incident with resident #013. As a result of the incident resident #012 sustained an injury which required treatment.
Resident #013 had a medical and behavioural history, with long standing interventions in place, as noted in their plan of care.
Resident #013 received an intervention immediately following the incident and subsequently was treated for a possible diagnosis.

Resident #012 was not protected from abuse.

Sources: Clinical health records including plans of care and progress notes for the two residents and interviews with staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that their written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy Abuse Prevention, Elimination and Reporting detailed the protocol for investigating allegations of resident abuse which included an Investigation of Allegations of Abuse form and a meeting with all parties identified in the incident.

According to the clinical record there was an allegation of resident abuse.

When requested the home was not able to produce records, in addition to the incident reports and clinical health records for the residents, regarding the incident or actions taken as part of an investigation.
Staff confirmed that they were not able to locate an Investigation of Allegations of Abuse form or other records related to the investigation into the incident.
Staff identified that they were in contact with the substitute decision maker (SDM) for the resident regarding the incident and that the resident was reassessed and had a current plan in place to meet their care needs.

The policy that promoted zero tolerance of abuse and neglect of residents was not followed.

Sources: Clinical health records of residents, review of Abuse Prevention, Elimination and Reporting policy and interviews with staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each evaluation of the responsive behaviours program that included the persons who participated in the evaluation, a summary of the changes made, and the date that the changes were implemented.

A review of the Quality Management Audit Report - Behaviour/Responsive Behaviour Management Audit and Evaluation was completed.
According to the tool, staff and family members were interviewed to identify their awareness of the program; however, the document did not include a written record of an evaluation and a summary of the changes made to the program, the dates when the changes were implemented nor the persons who participated in the evaluation.

The Administrator identified that there was an ongoing process of assessing and evaluating programs in the home; however, this was not consistently documented as part of the evaluation process.

An evaluation of the responsive behaviours program assists to ensure that the policy meets the needs of the residents of the home.

Sources: Quality Management Audit Report - Behaviour/Responsive Behaviour Management Audit and Evaluation and interview with staff. [s. 53. (3) (c)]

2. The licensee failed to ensure that the actions taken to meet the needs of residents with responsive behaviours included assessments, reassessments, interventions and that the resident's responses to the interventions were documented.

The home had a "responsive behaviour notes" template with "headings" to guide staff on information to document when a responsive behaviour occurred, including what happened prior to the incident, triggers or environmental factors, what was the behaviour and what happened as a result of the behaviour or what actions were taken.

A. A review of a resident’s clinical record included that they demonstrated responsive behaviours; however, the record did not consistently include documentation of the assessment, reassessments, interventions nor the resident's response.
i. An incident of responsive behaviours occurred, during the night shift, as recorded by PSW staff. There was no record of any assessments, interventions nor the resident's response.
ii. Later that day the resident displayed a behaviour towards a staff member.

Documentation included a pain assessment; however, there was no record of immediate interventions to manage the situation nor the resident's response.
A note following the incident identified that the SDM requested a meeting and an assessment was completed; however, this assessment, which included possible triggers did not include any interventions.
iii. The next month, PSW staff documented that the resident showed signs of a responsive behaviour. There was no record of any assessments, interventions nor the resident's response.

B. A second resident had a history of responsive behaviours.
The records for a period of 17 days identified that the resident, intermittently demonstrated responsive behaviours.
The documentation related to these incidents did not consistently include the actions taken to meet the resident's needs including the interventions nor the resident's response when the behaviours were demonstrated.

C. A third resident had a history of responsive behaviours.
The resident's medication was reduced and as a result their behaviours were monitored and dementia observation system charting was initiated a few days later.
A review of their records related to behaviours for a 17 day period of time identified that they intermittently demonstrated responsive behaviours.
The records only identified that the behaviour occurred.
A review of the progress notes, which allowed staff to document additional information including assessments, reassessments, interventions and the resident's response, for the same time period, included fewer incidents of responsive behaviours.

Not all actions taken to meet the needs of residents with responsive behaviours were documented.

Documentation of assessments, interventions and the resident's response assists in care planning to meet the needs of residents' who demonstrate responsive behaviours.

Sources: Progress notes, assessments and POC records for the residents and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record is kept relating to each evaluation of the responsive behaviours program that includes the persons who participated in the evaluation, a summary of the changes made, and the date that the changes are implemented and to ensure that the actions taken to meet the needs of residents with responsive behaviours including assessment, reassessments, interventions and the resident's responses to the interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

The licensee failed to ensure that the analysis of every incident of abuse or neglect was considered in the annual evaluation of the licensee's policy under section 20 of the Act, to promote zero tolerance of abuse and neglect of residents; that the changes and improvements identified were promptly implemented; and a written record of everything including the date of the evaluation, who participated in the evaluation, and the date that the changes and improvements were implemented was promptly prepared.

The Quality Management Audit Report Annual Evaluation - Resident Abuse and Neglect Policy was reviewed.
The tool included that staff were interviewed regarding their awareness of the policy; however, it did not include an analysis of the incidents of abuse; the changes and improvements identified/implemented; nor the persons who participated in the evaluation and the dates of actions taken.
It was identified that there was an ongoing process of assessing and evaluating programs in the home; however, this was not consistently documented as required.

An evaluation of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents assists to ensure that the policy meets the needs of the residents of the home.

Sources: Quality Management Audit Report Annual Evaluation - Resident Abuse and Neglect Policy and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the analysis of every incident of abuse or neglect is considered in the annual evaluation of the licensee's policy under section 20 of the Act, to promote zero tolerance of abuse and neglect of residents; that the changes and improvements identified are promptly implemented; and a written record of everything provided for including the date of the evaluation, who participated in the evaluation, and the date that the changes and improvements are implemented is promptly prepared, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a resident sustained a fall a post-fall assessment was conducted with a clinically appropriate assessment instrument that was specifically designed for falls.

According to the clinical record a resident sustained a fall which resulted in a transport to hospital.
A review of the clinical record included a referral to physical therapy and a falls risk assessment; however, the record did not include a post-fall assessment, with a clinically appropriate assessment instrument that was specifically designed for falls.

Post fall assessments assist in care planning in an effort to prevent future falls.

Sources: Review of progress notes and assessments completed for the resident, review of Risk Management notes both active and historical and interviews with staff.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

The licensee failed to ensure that a documented record of complaints received was reviewed and analyzed for trends at least quarterly.

According to the Client Services Response Forms, the home received two complaints in the fourth quarter of 2020, both which were managed to the satisfaction of the complainants.
A review of 2020 Complaint Quarterly Review Resident/Family Summary noted only one complaint for the time period, which was analyzed as part of the trends identified, actions taken and outcomes.
Interview with the Administrator confirmed that the second complaint was omitted in error.

Not all complaints received were included in the review and analyzed for trends for the final quarter of 2020 as required for determining improvements.

Sources: A review of Client Service Response Forms, Complaint Quarterly Review Resident/Family Summary and interview with staff. [s. 101. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

A licensee who was required to inform the Director of missing or unaccounted for controlled substances failed to within 10 days of becoming aware of the incident make a report in writing to the Director which set out with respect to the incident: the events that lead up to the incident; actions taken in response to the incident, and by whom; the outcome; analysis and follow-up actions, including the immediate actions that were taken to prevent recurrence, and the actions planned to correct the situation and prevent recurrence.

A CIS report was submitted for missing or unaccounted for controlled substance(s).
A review of the report did not specify what medications were missing or unaccounted for, the events that lead up to the incident, all of the actions taken in response to the incident and by whom, the outcome, analysis and follow up actions taken.
It was identified that the home had identified the concern during an audit of the emergency (stat) medications; however, due to a number of factors did not conduct an investigation into the discrepancies and provided the audit results to the pharmacy for follow up.
Nursing management confirmed that as a result of the unaccounted for medications there was a change in process related to who was to access the emergency (stat) medications, education was provided to team members regarding how to access the medications including required documentation and that the auditing schedule was adjusted in an effort to identify additional concerns.
Pharmacy staff identified that they did not conduct an investigation into all of the unaccounted for narcotics and controlled substances from the audit; however, were successful in identifying when some of the medications were used and on which resident (s). They also identified that a subsequent audit of the emergency (stat) medications was completed and although initially the documentation identified that there were unaccounted for controlled substances they were successfully located during the review process.

The licensee did not inform the Director of the additional information required within 10 days of becoming aware of the incident.

The reporting of CIS reports and actions taken as a result to the Director are used to identify concerns and trends.

Sources: CIS report and discussion with staff.

Issued on this 6th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2021_556168_0003
Log No. / No de registre :	004188-20, 022641-20, 025037-20, 025375-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 29, 2021
Licensee / Titulaire de permis :	Grace Villa Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Grace Villa Nursing Home 45 Lockton Crescent, Hamilton, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janette West

To Grace Villa Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with section 19 (1) of the LTCHA.

Specifically the licensee shall ensure that resident #013 does not abuse any other resident in the home.

Grounds / Motifs :

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

1. The licensee failed to ensure that all residents were protected from abuse.

According to the clinical record resident #012 was involved in an incident with resident #013. As a result of the incident resident #012 sustained an injury which required treatment.
Resident #013 had a medical and behavioural history, with long standing interventions in place, as noted in their plan of care.
Resident #013 received an intervention immediately following the incident and subsequently was treated for a possible diagnosis.

Resident #012 was not protected from abuse.

Sources: Clinical health records including plans of care and progress notes for the two residents and interviews with staff.

An order was made by taking the following factors into account:
Severity: The incident of resident abuse resulted in actual harm to resident #012.
Scope: The scope of this non-compliance was isolated as identified by the review of three residents during this inspection.
Compliance History: This subsection was issued as a compliance order CO on April 23, 2018, during inspection 2018_587129_0004 and on November 28, 2018, during inspection 2018_704682_0023.
Both of these orders were complied on April 17, 2019.
Two other COs were issued to the home in the past 36 months.
(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 09, 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, 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

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 29th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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