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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2022	2022_943988_0007	017668-21, 019647-21, 019734-21, 019848-21	Complaint

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

PARMINDER GHUMAN (706988), ANGELA FINLAY (705243), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 22, 23, 24, 25, 28, March 1, 2, 3, 4, 7, 8, 9, 10 & 15, 2022

The following intake was completed during this Complaint inspection:
Log #017668-21 related to IPAC protocols not being followed, Call bell not reachable/responded to and toileting care issue
Log #019647-21 related to sexual abuse from male resident to female resident.
Log #019734-21 related to sexual abuse.
Log #019848-21 related to resident to resident sexual abuse, responsive behaviours, and recreational and social activities program.

The Critical Incident System (CIS) inspection # 2022_943988_0006 was completed concurrently with this Complaint inspection.

PLEASE NOTE: A Voluntary Plan of Correction related to Long-Term Care Homes Act (LTCHA) chapter (c.) 8, section (s.) 6 (7), identified in a concurrent Critical Incident inspection (#2022_943988_0006) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Executive Director (AED), Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) and residents.

During the course of the inspection, the inspectors toured the home, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, 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
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **1 VPC(s)**
- **3 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. 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the intervention for the resident was provided as specified in the plan of care.

This resident had a history of responsive behaviours. An intervention was initiated in response to their behaviours.

The resident was found alone with another resident. The intervention for responsive behaviour was not being provided as specified in the plan of care.

In separate interviews with a PSW, RPN and the DOC, they all stated that the responsive behaviour intervention was not being provided.

Failure to provide responsive behaviour intervention as specified in the plan of care resulted in a risk of harm to the other residents.

Sources: Resident’s clinical records, Grace Villa’s investigation notes, Interviews with PSW , RPN , and the DOC. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan related to requests for assistance.

During an observation, the call bell display panel identified that the bed side call bell for resident had been activated for 44.52 minutes.

A review of the plan of care identified that the resident was at falls risk and included interventions to respond promptly to all requests for assistance.

Failure to provide care as set out in the plan of care related to prompt responses to requests potentially put the resident at risk for a fall.

Sources: Observations of the call bell display panel and resident , review of the plan of care for resident and interview with PSW and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan related to requests for assistance.

During an observation, the call bell display panel identified that the bed side call bell for resident had been activated for 30 minutes.
The resident reported later in the shift that they activated the call bell to use the bathroom and confirmed a delay in staff response to the bell.

A review of the plan of care identified that the resident was at falls risk and included interventions to ensure that the call bell was in reach, to encourage use of the bell and to respond promptly to all requests for assistance.

Failure to provide care as set out in the plan of care related to prompt responses to requests potentially put the resident at risk for a fall.

Sources: Observations of the call bell display panel and resident, review of the plan of care for resident and interview with PSW and other staff. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plans of care was provided to two residents as specified in their plans.

i. The plan of care for first resident identified a potential risk and the need to be assessed quarterly and with a change in condition or unsafe habits. The assessments were completed on two different dates; however, not quarterly as set out in the plan.

ii. The plan of care for second resident identified a potential risk and the need to be assessed quarterly, as needed and with a change in condition or unsafe habits.

The assessments were completed on three different dates, however, not quarterly as set out in the plan.

Failure to reassess the residents as set out in the plans of care had the potential for a change in need or risk level identified or managed as required.

Sources: A review of the assessments and plan of care for both residents, observations and interview with resident and interviews with RPN and other staff. (168) [s. 6. (7)]

5. The licensee has failed to ensure that the provision of responsive behaviour intervention was documented.

The resident required responsive behaviour intervention. When requested, the home was not able to produce documentation confirming that this intervention was provided.

In an interview with the ED, AED, and DOC, they stated that the home should have kept this documentation but could not locate them.

Sources: Resident’s clinical records, and an interview with the ED, AED, and DOC. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the provision of responsive behaviour intervention was documented for the resident.

The resident required responsive behaviour intervention. No documentation was found for four dates and incomplete documentation was found for another four dates.

In an interview with the DOC, they stated that it is the expectation for Grace Villa staff to document in the progress notes that the responsive behaviour intervention was provided.

During the course of intervention there were many dates where there were no progress notes indicating that resident was receiving responsive behaviour intervention as specified in the plan of care.

Sources: Resident’s clinical records, and interview with DOC. [s. 6. (9) 1.]

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 to ensure that care set out in the plan of care is provided to the resident as specified in the plan and that the provision of care is documented, to be implemented voluntarily.

WN #2: 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 identified resident was protected from abuse by another resident.

This resident had a history of responsive behaviours that required an intervention.

Registered staff found the resident alone with another resident and suspected that abuse had occurred. Management initiated investigation of the abuse and Police were called to the home, resident was taken to hospital.

The CEO of APANS Health Services had stated in an e-mail, that an abuse had occurred.

In an interview with registered staff, they stated that the incident was handled as an assault. The DOC had stated that the responsive behaviour intervention was not provided as specified in the plan of care and therefore it did not protect the resident from abuse.

A failure to protect resident from abuse had a potential to cause harm or distress to the resident.

Sources: Both resident's clinical records, Grace Villa's investigation notes, interviews with PSW, registered staff, and the DOC. [s. 19. (1)]

Additional Required Actions:

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

WN #3: 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 :

The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

a) During an observation, two PSWs entered into Droplet & Contact Precautions room without wearing N95 respirator and face shield. The room had an additional precautions sign clearly visible on the door. This happened twice as one of the PSW entered into Droplet & Contact Precautions room to provide meal tray to the resident and to be with the resident till they finish their meal by not putting N95 and earlier to provide care to the resident. Even for the second time PSW wore other PPE as per the posted signage but did not follow the directions for N95. Another PSW entered into another Droplet/Contact precautions room by not wearing appropriate PPE. This PSW entered the room without wearing face shield to deliver the lunch tray for the resident. It was observed that PSW was less than two meters from the resident.

b) On another date, another PSW entered into an additional precautions room (Contact Precautions) to provide care to the resident with another PSW. When one of the PSWs came out of the room, they were not wearing any gown and gloves and they took assistive device to the resident's room without wearing any gown and gloves.

RPN and DOC confirmed that the expectation for Droplet/Contact Precautions is that staff wears N95 and Face shield when they enter into a room. For Contact Precautions staff should wear gown and gloves when they enter the room for transfers and for the provision of care.

The residents were at risk for infection as staff did not use appropriate PPE for additional precaution rooms.

Sources: Observation of the resident home area, review of Appendix 111: Guidelines-Droplet Precautions, Reference #005090.00(c), Overview of Infection Control Program Reference # 001020.00 and interview with RPN and DOC. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident was bathed twice a week unless contraindicated by a medical condition.

A PSW identified that resident was not bathed as scheduled.
Point of Care (POC) records identified the frequency of bathing was twice a week.
POC records identified that the resident was bathed weekly; however, there was no documentation to support that bathing was offered, contraindicated or completed bi-weekly.

Failure to provide bathing at the frequency of twice a week had the potential to impact the resident's hygiene.

Sources: POC records for resident and interview with PSW. [s. 33. (1)]

WN #5: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record of a complaint regarding abuse of the resident was kept.

A review of the progress notes indicated that the SDM of the resident voiced concerns relating to abuse of the resident by staff.

Grace Villa's complaints policy titled, “Response to Complaints,” stated that the ED would start an investigation into any complaints alleging harm immediately and would contact the complainant to arrange a follow-up meeting to discuss the findings of the investigation and solutions. It also states that the ED would document the complaint on the Dispute Resolution Form (Resident/ Family) and a record of this would be kept and filed in the home.

In an interview with the ED they stated that the SDM was followed-up with, however, the home did not start a Dispute Resolution Form (Resident/ Family) and no record of the follow-up meeting to discuss the findings of the investigation and solutions with the SDM was kept.

Sources: Resident’s clinical records, Grace Villa’s Complaint Policy, “Response to Complaints,” and an interview with the ED. [s. 101. (2)]

Issued on this 30th day of March, 2022

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) :	PARMINDER GHUMAN (706988), ANGELA FINLAY (705243), LISA VINK (168)
Inspection No. / No de l’inspection :	2022_943988_0007
Log No. / No de registre :	017668-21, 019647-21, 019734-21, 019848-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 28, 2022
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 :	Glynis Cox

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. 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 LTCHA.

Specifically, the licensee must:

1) Provide information and education to all direct care staff and agency staff regarding the expectation of responsive behaviour intervention.

2) Keep a record of this information and education, including the information provided, the date and a signature of the persons receiving the information.

3) Ensure that all staff or agency staff document that the responsive behaviour intervention was provided as specified in the plan of care, the length of time this was provided, and a signature of the provider.

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 has failed to ensure that the intervention for the identified resident was provided as specified in the plan of care.

This resident had a history of responsive behaviours. An intervention was initiated in response to their behaviours.

The resident was found alone with another resident. The intervention for responsive behaviour was not being provided as specified in the plan of care.

In separate interviews with a PSW, RPN and the DOC, they all stated that the responsive behaviour intervention was not being provided

Failure to provide responsive behaviour intervention as specified in the plan of care resulted in a risk of harm to the other residents.

Sources: Resident's clinical records, Grace Villa's investigation notes, Interviews with PSW , RPN , and the DOC.
An order was made by taking the following factors into account:

Severity: Not providing responsive behaviour intervention as specified in the plan of care for this identified resident resulted in an actual risk of harm to the other resident.

Scope: The scope of this non-compliance was isolated as identified by a review of three residents who required responsive behaviour intervention.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) where a Voluntary Plan of Correction (VPC) was issued, and a Written Notification (WN) was issued. (705243)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2022

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 : 002

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 s. 19 of LTCHA.

Specifically, the licensee must:

1) Ensure identified resident and all other residents are protected from abuse.

2) Ensure all residents with responsive behaviours are assessed to determine appropriate interventions and all interventions as per assessed needs are being provided.

Grounds / Motifs :

1. The licensee has failed to ensure that identified resident was protected from abuse by another resident.

This resident had a history of responsive behaviours that required an intervention.

Registered staff found the resident alone with another resident and suspected that abuse had occurred. Management initiated investigation of the abuse and Police were called to the home, resident was taken to hospital.

The CEO of APANS Health Services had stated in an e-mail, that an abuse had occurred.

In an interview with registered staff, they stated that the incident was handled as an assault. The DOC had stated that the responsive behaviour intervention was not provided as specified in the plan of care and therefore it did not protect the resident from abuse.

A failure to protect resident from abuse had a potential to cause harm or distress to the resident.

Sources: Both resident's clinical records, Grace Villa's investigation notes, interviews with PSW, registered staff, and the DOC.

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

Severity: The incident of abuse resulted in an actual risk of harm to resident.

Scope: The scope of this non-compliance was isolated as there were no other incidents of abuse.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 19 (1) where a Compliance Order (CO) was issued, and was complied with. (705243)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 29, 2022

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 : 003

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) Provide re-training to identified PSWs on Infection Prevention and Control (IPAC) practices, specifically regarding appropriate use of Personal Protective Equipment (PPE) for additional precautions.

2) A record of this training must be kept, including the training material provided, the date and a signature of the persons who attended.

3) Audit identified PSWs and any other staff entering additional precautions room on the appropriate use of PPE . At least one audit must be completed per day until no further concerns arise with the specified staff following IPAC practices in accordance with the licensee's policy. A record of the audits must be kept for Long-Term Care Home (LTCH) Inspector review.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

a) During an observation, two PSWs entered into Droplet & Contact Precautions room without wearing N95 respirator and face shield. The room had an additional precautions sign clearly visible on the door. This happened twice as one of the PSW entered into Droplet & Contact Precautions room to provide meal tray to the resident and to be with the resident till they finish their meal by not putting N95 and earlier to provide care to the resident. Even for the second time PSW wore other PPE as per the posted signage but did not follow the

directions for N95. Another PSW entered into another Droplet/Contact precautions room by not wearing appropriate PPE. This PSW entered the room without wearing face shield to deliver the lunch tray for the resident. It was observed that PSW was less than two meters from the resident.

b) On another date, another PSW entered into an additional precautions room (Contact Precautions) to provide care to the resident with another PSW. When one of the PSWs came out of the room, they were not wearing any gown and gloves and they took assistive device to the resident's room without wearing any gown and gloves.

RPN and DOC confirmed that the expectation for Droplet/Contact Precautions is that staff wears N95 and Face shield when they enter into a room. For Contact Precautions staff should wear gown and gloves when they enter the room for transfers and for the provision of care.

The residents were at risk for infection as staff did not use appropriate PPE for additional precaution rooms.

Sources: Observation of the resident home area, review of Appendix 111: Guidelines- Droplet Precautions, Reference #005090.00(c), Overview of Infection Control Program Reference # 001020.00 and interview with RPN and DOC.

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

Severity: The residents were at actual risk of harm when staff did not use appropriate PPE when entering and exiting resident rooms.

Scope: Two out of three staff observed did not did not use appropriate PPE for additional precautions rooms.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. s.229 (4) where a Voluntary Plan of Correction (VPC) was issued to the home. (706988)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jun 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Parminder Ghuman

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