Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 04, 2019	2019_695156_0001 (A1)	028258-18, 032838-18, 032839-18, 002932-19, 003091-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

Amended by CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

amendment to compliance due date

Issued on this 4 th day of June, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
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Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

Amended by CAROL POLCZ (156) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 26, 27, 28, 29, April 3, 4, 8, 9, 10, 11, 15, 16, 17, 23, 2019.

The following CIS inspection and Follow-up inspections were inspected concurrently with this inspection:

Critical Incident System Inspection (CIS):

028258-18, #2570-000016-18 related to transferring and positioning

002932-19, #2570-000003-19 related to transferring and positioning

Follow-up Inspections:

032838-18 follow up to CO #002 from inspection 2018_570528_0002/005152-18 related to s. 8 (3)

032839-18 follow up to CO #003 from inspection 2018_570528_0002/005152-18 related to s. 19 (1)

003091-19 follow up to CO #001 from inspection 2018_543561_0017/126406-18 related to s. 6 (7)

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Nurse Practitioner (NP), Nursing Scheduling Coordinator, Reception/Unit Scheduling Coordinator (Acting), Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2018_570528_0002	156

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #007 indicated that the resident was to have falls prevention interventions which were initiated in March, 2019.

The resident was observed by the inspector and PSW #109 on an identified date in April, 2019 where it was noted that one of the falls prevention interventions was not in place at that time. PSW #109 confirmed that the care set out in the plan of care in relation to the intervention was not provided to the resident as specified in the plan.

This area of non-compliance was identified in relation to Follow-up inspection #003091-19. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a CI report log #028258-18 in October, 2018 reporting an injury to resident #001 during a transfer. There were no immediate injuries, however, injuries were noted at a later time. A medical device was applied and the plan of care was updated. According to the progress notes, the medical device was removed in November, 2018.

The plan of care was not revised to reflect the change in the resident's care needs with regards to the removal of the medical device and care that was no longer necessary until an identified date in March, 2019 as confirmed with the ADOC.

This area of non-compliance was identified in relation to CIS inspection #028258-18. [s. 6. (10) (b)]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Foxridge Care Community is a long-term care home with a licensed capacity of 122 beds.
The DOC verified the staffing pattern for the home included at least one Registered Nurse (RN), not including the DOC, on duty and present at all times, in addition to a mix of Registered Practical Nurses (RPNs) and Personal Support Workers to meet the needs of residents.
Interview with the DOC identified that currently the home has a sufficient number of RNs on staff to achieve their staffing plan.
It was identified by the DOC that the home does not utilize the services of nursing agencies to fill vacant shifts.

The registered nurse staffing schedules and master daily rosters were provided from an identified date in March to April, 2019, on request.
A review of the daily rosters and schedules indicated that over the identified time period there were three occasions where there was not at least one registered nurse on duty and present at all times as confirmed by the Nursing Scheduling Coordinator.

a) On an identified date in March, 2019, the scheduled RN called in for the day shift (0700-1500 hours) and was not replaced. The home identified that the Nurse Practitioner (NP) who was funded by the Ministry of Health and Long-Term Care was in the home from the hours of 0830-1630 hours, however, was working as an NP, not in the capacity of the RN.

b) On an identified date in March, 2019, the scheduled RN had called in for the night shift (2300-0700 hours) and was not replaced.

c) On an identified date in March, 2019, the scheduled RN had called in for the day shift (0700-1500 hours) and was not replaced. The home identified that the Nurse Practitioner (NP) who was funded by the Ministry of Health and Long-Term Care was in the home from the hours of 0830-1630 hours, however, was working as an NP, not in the capacity of the RN.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

This non-compliance was identified as a result of Follow-up inspection #032838-18. [s. 8. (3)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: 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 failed to ensure that 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, is complied with.

A) In accordance with O. Reg., s, 114 (1) the licensee is required to develop and implement an interdisciplinary medication management system that provides for safe medication management.

Specifically, the staff did not comply with the home's policy "Documentation & Record Keeping, policy 8-1 dated February, 2017" which stated that "the Medication Administration Record (MAR) is a legal document listing all medications prescribed for an individual resident. The MAR is used to document all medications administered, not administered, or refused by a resident. MARS may be maintained in electronic (e-MAR) or paper versions."

The Administrator confirmed that the home used an electronic version of the MAR and that this was the policy for the home to follow.

The policy indicated that the procedure was that staff were to chart all medications administered by signing their initials in the appropriate box corresponding to correct mediation, date, and time on the MAR sheet and "failure to chart a medication that has been given or not given is considered a medication incident and must be reported'.

i) On an identified date in March, 2019, registered staff #103 confirmed that in

January, 2019, they administered a dose of PRN (as needed) Tylenol to resident #004. The staff confirmed that they did not document the administration of this medication on the e-MAR and that they did not report the omission as a "medication incident". The Administrator confirmed the lack of documentation and failure to complete an incident report at the time of the incident.

B) In accordance with O. Reg., s, 52 the licensee is required to develop and implement a pain management program.

Specifically, the staff did not comply with the home's policy "Pain and Symptom Management, policy VII-G-30.10, dated October, 2018" which stated that registered staff will screen for presence of pain and complete a pain assessment electronically when a resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions". Interview with the DOC reported that any time the resident had a Pain Assessment in Advanced Dementia (PAINAD) score of more than 4, more than once in a 24 hour period, the pain assessment was to be completed.

i) On an identified date in February, 2019, the e-MAR indicated that resident #004 was administered an identified medication at 0800 hours, 1200 hours, 1700 hours, and 2100 hours that day. The clinical record indicated that the resident had a PAINAD score of five out of ten at 1616 hours and score of five out of ten at 1805 hours indicating that the resident exhibited symptoms of pain, however, a pain assessment was not completed until the following morning at 0957 hours as confirmed with the Administrator.

ii) On an identified date in October, 2018, the e-Mar indicated that resident #001 was administered an identified medication at 0511 hours and had a PAINAD score of six out of ten at that time indicating that the resident exhibited symptoms of pain. The PAINAD score was noted to be seven out of ten at 0749 hours and again at 0846 hours indicating that the resident was still exhibiting symptoms of pain. At 1324 hours, the resident had a PAINAD score of six out of ten indicating that the resident exhibited symptoms of pain. A pain assessment was not completed as per policy for the resident during this time period as confirmed with the Administrator.

This area of non-compliance was identified in relation to CIS inspection #002932-19. [s. 8. (1) (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 to ensure that 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, was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report log #002932-19 in February, 2019 reporting an injury to a resident.

On an identified date in January, 2019, resident #004 received personal care by PSW staff #100. The resident had been assessed to require two staff in the provision of personal care including positioning and bed mobility. PSW staff #100 provided personal care to the resident on their own when the resident sustained an injury.

PSW staff #100 confirmed that they did not use safe positioning techniques when assisting resident #004 when the care was not provided by two staff as per the plan of care and which resulted in injury.

This area of non-compliance was identified in relation to CIS inspection #002932-19.

The above is further evidence to support the order issued on December 3, 2018 during Resident Quality Inspection (RQI) 2018_543561_0016/023251-18 to be complied by June 3, 2019. [s. 36.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A review of the clinical record including the progress notes for resident #008 indicated that in March, 2019 the resident had an area of altered skin integrity. This area of altered skin integrity was not found to be assessed using a clinically appropriate assessment instrument specifically designed for skin and wound assessment by a member of the registered nursing staff. This was confirmed with the DOC.

This area of non-compliance was identified in relation to Follow-up inspection #032839-18.

The above is further evidence to support the order issued on February 21, 2019 during Complaint Inspection 2018_570528_0002 (A2)/005152-18 (A2) to be complied by June 3, 2019. [s. 50. (2) (b) (i)]

Issued on this 4 th day of June, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by CAROL POLCZ (156) - (A1)
Inspection No. / No de l'inspection :	2019_695156_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	028258-18, 032838-18, 032839-18, 002932-19, 003091-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 04, 2019(A1)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fox Ridge Care Community 389 West Street, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Croley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_543561_0017, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must:

1. Ensure all residents in the home including resident #007 that are at risk for falls are provided with falls prevention interventions as specified in the plan of care.

2. Develop an auditing system of residents who require falls prevention interventions to ensure these interventions are in place.

3. Keep a documented record of the audits completed.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #007 indicated that the resident was to have falls prevention interventions which were initiated in March, 2019.

The resident was observed by the inspector and PSW #109 on an identified date in April, 2019 where it was noted that one of the falls prevention interventions was not in place at that time. PSW #109 confirmed that the care set out in the plan of care in relation to the intervention was not provided to the resident as specified in the plan.

This non-compliance was issued as a result of follow-up inspection #003091-19 which was completed concurrently with Critical Incident System (CIS) Inspection 2019_695156_0001.

The severity of the issue was determined to be a level 2 as there was potential for actual risk to the residents. The scope of the issue was determined to be a level 1 isolated as it related to one out of three residents reviewed. The home had a level 4 history with on-going non-compliance with this section of the Act that included a previous voluntary plan of correction (VPC) issued in April 2017 (2017_556168_0010), April 2016 (2016_337581_0003), November 2015 (2015_188168_0026) and a compliance order (CO) issued in February 2019 (2018_543561_0017). (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2019

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_570528_0002, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA, 2007.

Specifically, the licensee must ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

To achieve this requirement, the licensee shall develop and implement written strategies in an effort to ensure coverage of vacation relief and sick or absent calls for regular RNs.

Grounds / Motifs :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Foxridge Care Community is a long-term care home with a licensed capacity of 122 beds.
The DOC verified the staffing pattern for the home included at least one Registered Nurse (RN), not including the DOC, on duty and present at all times, in addition to a mix of Registered Practical Nurses (RPNs) and Personal Support Workers to meet

the needs of residents.
Interview with the DOC identified that currently the home has a sufficient number of RNs on staff to achieve their staffing plan.
It was identified by the DOC that the home does not utilize the services of nursing agencies to fill vacant shifts.

The registered nurse staffing schedules and master daily rosters were provided from an identified date in March to April, 2019, on request.
A review of the daily rosters and schedules indicated that over the identified time period there were three occasions where there was not at least one registered nurse on duty and present at all times as confirmed by the Nursing Scheduling Coordinator.

a) On an identified date in March, 2019, the scheduled RN called in for the day shift (0700-1500 hours) and was not replaced. The home identified that the Nurse Practitioner (NP) who was funded by the Ministry of Health and Long-Term Care was in the home from the hours of 0830-1630 hours, however, was working as an NP, not in the capacity of the RN.

b) On an identified date in March, 2019, the scheduled RN had called in for the night shift (2300-0700 hours) and was not replaced.

c) On an identified date in March, 2019, the scheduled RN had called in for the day shift (0700-1500 hours) and was not replaced. The home identified that the Nurse Practitioner (NP) who was funded by the Ministry of Health and Long-Term Care was in the home from the hours of 0830-1630 hours, however, was working as an NP, not in the capacity of the RN.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

This non-compliance was issued as a result of follow-up inspection #032838-18 which was completed concurrently with Critical Incident System (CIS) Inspection 2019_695156_0001.

The severity of the issue was determined to be a level 2 as there was potential for

actual risk to the residents. The scope of the issue was determined to be a level 2 pattern as there were three occurrences between the identified dates in March, 2019. The home had a level 4 history with on-going non-compliance with this section of the Act that included a previous written notification (WN) issued in June 2017 (2017_556168_0022) and a compliance order (CO) issued in February 2019 (2018_570528_0002). (156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2019(A1)

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 4 th day of June, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by CAROL POLCZ (156) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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