Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central West Service Area Office
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Bureau régional de services de Centre Ouest
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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 12, 2021	2021_836766_0004	002760-20, 012707-20, 012708-20, 012709-20, 012710-20	Follow up

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street Creemore ON L0M 1G0

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

KATY HARRISON (766), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 27, 28, 29, February 1-5, 8-11,17, 2021.

The following intakes were completed within the Follow up inspection:

Log #002760-20, Follow-up to CO#001 from inspection #2020_773155_0001 related to twenty-four-seven Registered Nurse;

Log #012707-20, Follow-up to CO #001 from inspection #2020_781729_0005 related to Falls and Nutrition and Hydration;

Log #012708-20, Follow-up to CO#001 from inspection #2020_781729_0006 related to Responsive Behaviours;

Log #012709-20, Follow-up to CO#002 from inspection #2020_781729_0005 related to staff training;

Log #012710-20, Follow-up to CO#003 from inspection #2020_781729_0005 related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Clinical Consultant, Director of Compliance (CCDC), Director of Care (DOC), Assistant Director of Care (ADOC), Food Service and Supports Manager (FSSM), Registered Dietician (RD), Resident Relations Coordinator (RRC), Director of Programs and Activities (DOPA), RAI-Coordinator (RAI-C), Physiotherapist, Nursing Scheduling Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), RPN Student, Personal Support Worker (PSW), Care Support Assistant (CSA), Dietary Aide, Maintenance and Housekeeping.

The inspector (s) also toured the home and resident care areas, observed the provision of resident care, staff-resident interactions, meal service, reviewed relevant clinical records, policies and procedures, education records, critical incident system forms and the Daily Nursing Roster.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **3 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
O.Reg 79/10 s. 31. (3)	CO #003	2020_781729_0005	155
O.Reg 79/10 s. 53.	CO #001	2020_781729_0006	766
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2020_781729_0005	766
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2020_773155_0001	155

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care in relation to nutrition and hydration was provided to three residents as specified in the plan.

The Food and Support Services Manager (FSSM) stated that the styrofoam cup filled to the bottom lip held less than two servings, 175 mls.

Fluids were observed being served to residents in the dining room during the breakfast meal. The fluids were served to all residents in either a styrofoam cup or a plastic cup. The inspector spoke to three PSWs and they each indicated a different serving size for the plastic and styrofoam cups, ranging between 125 and 175 mls.

Three residents did not receive the 250 mls of fluid as directed by their plan of care which put them at potential risk of dehydration and weight loss.

Sources: Observations; Care Plan; Kardex; Interviews with the RD, FSSM, and PSWs. [s. 6. (7)]

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident reported an allegation of staff to resident abuse and an allegation of neglect that it was immediately investigated.

a) A resident reported an incident involving a PSW related to verbal abuse. The resident and the PSW that witnessed the incident reported to the DOC at the time it happened.

The DOC recalled the incident but could not provide any investigation notes.

b) The same resident reported that another PSW refused to provide care.

There was no documentation of an investigation in relation to the allegations. As a result of these allegations not being immediately investigated, there was risk of further abuse and neglect of the resident and other residents.

Sources: progress notes, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); interviews with the resident, a PSW, DOC and other staff. [s. 23. (1) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident reported an allegation of alleged staff to resident abuse and an allegation of alleged neglect by staff, that resulted in harm or risk of harm to the resident, that it was immediately reported to the Director.

a) A resident reported an incident involving a PSW related to verbal abuse. They reported the incident to the DOC when it happened. Another PSW also reported the incident at the time it happened to the charge nurse and the DOC.

b) A resident was put on heightened monitoring for alleging that a PSW refused to provide care.

The incidents of alleged verbal abuse and alleged neglect involving the resident were not reported to the Director. There was potential for harm to other residents as the staff involved would have continued to work.

Sources: progress notes, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); critical incident system forms submitted by the home, interviews with the resident, a PSW, RPN and other staff. [s. 24. (1)]

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a Registered Practical Nurse kept their medication cart secured and locked.

The medication cart was left unattended and unlocked outside of a residents room door. The RPN was inside the room.

A resident started touching and pushing the medication cart while the RPN yelled at the resident to leave the cart alone.

There was a risk that the resident could have obtained medications from the unlocked medication cart.

Sources: observations of the medication care and interview with Assistant Director of Care. [s. 129. (1) (a) (ii)]

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 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,, to be implemented voluntarily.

Issued on this 18th day of March, 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) :	KATY HARRISON (766), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2021_836766_0004
Log No. / No de registre :	002760-20, 012707-20, 012708-20, 012709-20, 012710-20
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 12, 2021
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Creedan Valley Care Community 143 Mary Street, Creemore, ON, L0M-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_781729_0005, 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 c. 8, s. 6 (7) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the care set out in the plan of care related to hydration interventions are provided to resident #002, #004, #005, as specified in the plan.

b) Ensure that staff are aware of the serving size of all cups used by the residents and accurately document fluid intake for resident #002, #004 and #005.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the care set out in the plan of care in relation to nutrition and hydration was provided to three residents as specified in the plan.

The Food and Support Services Manager (FSSM) stated that the styrofoam cup filled to the bottom lip held less than two servings, 175 mls.

Fluids were observed being served to residents in the dining room during the breakfast meal. The fluids were served to all residents in either a styrofoam cup or a plastic cup. The inspector spoke to three PSWs and they each indicated a different serving size for the plastic and styrofoam cups, ranging between 125 and 175 mls.

Three residents did not receive the 250 mls of fluid as directed by their plan of care which put them at potential risk of dehydration and weight loss.

Sources: Observations; Care Plan; Kardex; Interviews with the RD, FSSM, and PSWs. [s. 6. (7)]

An order was made by taking the following into account:

Severity: The severity of this issue was minimal risk of harm to the residents.

Scope: The scope of the issue was widespread as it related to three of the three residents reviewed.

Compliance History: The home had a level 4 history of on-going non-compliance with this subsection of the Act.

A compliance order (CO) is being re-issued for the licensee failing to comply with s. 6 (7) of O. Reg 79/10. This subsection was issued as a DR on June 8, 2020, during inspection #2020_781729_0005 with a compliance due date of December 20, 2020 (A2).

Additionally, the LTCH has a history of 45 other compliance orders in the last 36 months. (766)

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

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. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23.(1) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the DOC documents allegations of abuse that are reported and that they are immediately investigated

b) Ensure that the DOC receives education/training on how to investigate alleged, suspected or witnessed incidents of abuse or neglect. A copy of this education/training, date education/training was provided, and who provided the education/training will be kept available in the home.

c) That an audit be developed and conducted to ensure that all alleged, suspected or witnessed incidents of abuse or neglect are immediately investigated and that the investigation is complete. This audit will be kept available in the home and include the date of the audit, who conducted the audit, if any deficiencies were identified and actions taken to correct deficiencies.

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident reported an allegation of staff to resident abuse and an allegation of neglect that it was immediately investigated.

a) A resident reported an incident involving a PSW related to verbal abuse. The resident and the PSW that witnessed the incident reported to the DOC at the time it happened.

The DOC recalled the incident but could not provide any investigation notes.

b) The same resident reported that another PSW refused to provide care.

There was no documentation of an investigation in relation to the allegations. As a result of these allegations not being immediately investigated, there was risk of further abuse and neglect of the resident and other residents.

Sources: progress notes, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); interviews with the resident, a PSW, DOC and other staff. [s. 23. (1) (a)]

An order was made by taking the following into account:

Severity: There was minimal risk of harm to the residents.

Scope: The scope of the issue was a pattern as it related to two of the three residents reviewed.

Compliance History: The home had on-going non-compliance with this subsection of the Act that included:

Written Notification (WN) issued August 28, 2018, (2018_742527_0013)

Additionally, the LTCH has a history of 45 other compliance orders in the last 36 months. (155)

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 : Mar 31, 2021

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s.24.(1) of the LTCHA.

Specifically, the licensee must:

a) Ensure that the DOC or any other person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident; shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when a resident reported an allegation of alleged staff to resident abuse and an allegation of alleged neglect by staff, that resulted in harm or risk of harm to the resident, that it was immediately reported to the Director.

a) A resident reported an incident involving a PSW related to verbal abuse. They reported the incident to the DOC when it happened. Another PSW also reported the incident at the time it happened to the charge nurse and the DOC.

b) A resident was put on heightened monitoring for alleging that a PSW refused to provide care.

The incidents of alleged verbal abuse and alleged neglect involving the resident were not reported to the Director. There was potential for harm to other residents as the staff involved would have continued to work.

Sources: progress notes, Prevention of Abuse & Neglect of a Resident Policy (dated April 2019); critical incident system forms submitted by the home, interviews with the resident, a PSW, RPN and other staff.

An order was made by taking the following into account:

Severity: There was minimal risk of harm to the residents by not reporting immediately to the Director.

Scope: The scope of the issue was a pattern as it related to two of the three residents reviewed.

Compliance History: The home had on-going non-compliance with this subsection of the Act that included:

Voluntary Plan of Correction (VPC) issued August 29, 2018, (2018_742527_0012);
VPC issued May 22, 2019, (2019_773155_0007);
VPC issued October 3, 2019, (2019_781729_0018);
VPC issued January 21, 2020, (2021_773155_022

Additionally, the LTCH has a history of 45 other compliance orders in the last 36 months. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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:

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 12th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katy Harrison

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