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
1st Floor, 609 Kumpf Drive
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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
Aug 18, 2021	2021_610633_0014	004739-21, 005383-21, 005384-21, 011418-21	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

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

The Village of Riverside Glen
60 Woodlawn Road East Guelph ON N1H 8M8

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

SHERRI COOK (633)

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): July 28-30, August 2-6, 2021.

The following was completed during this inspection:

Follow Up (FU) to compliance orders (COs) #001 and #002 from inspection 2021_792659_0005 related to falls prevention and plan of care and critical incidents (CIs) related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Assistant GM (A-GM), the Director of Nursing Care (DONC), Assistant Directors of Nursing Care (A-DONCs), the Director of Environmental Services (DES), a Neighbourhood Coordinator (NC), the Charge Nurse Registered Nurse (CN/RN), a Behavioural Supports Ontario (BSO) team member, the Resident Assessment Instrument Coordinator (RAI-C), a Registered Practical Nurse (RPN), an exercise therapist, a Personal Support Worker (PSW), a screener, a housekeeper, Wellington, Dufferin, Guelph Public Health (PH) representatives and residents.

The inspector(s) toured the home, observed IPAC practices, heating/cooling, and staff and resident interactions. The plan of care for the identified residents, the home's related policies and documentation were reviewed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 6. (11)	CO #002	2021_792659_0005	633
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_792659_0005	633

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 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 staff fully participated in the implementation of the home's Infection Prevention and Control (IPAC) program in relation to performing hand

hygiene for staff and residents.

The home's hand hygiene policy stated that the home participated in the Ontario's Just Clean Your Hands in Long Term-Care program which described when staff and resident hand hygiene should be completed.

Observations of staff/resident hand hygiene showed the following:

On three dates, on two resident home areas (RHAs), eight staff members did not perform hand hygiene as required and resident hand hygiene was not completed.

There was no hand hygiene signage posted on Eramosa RHA in the hallways, nurses station and lounge area to act as a reminder for staff and visitors.

Sources: Observations (two RHA's); the home's hand hygiene policy (undated), Just Clean Your Hands Long Term Care Keeping Residents Safe and Healthy (2011), Just Clean Your Hands Long Term Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition (April 2014), Coronavirus Disease 2019 (COVID-19); interviews with a PSW and a resident.

2. The licensee failed to ensure that all staff participated in the implementation of the home's required COVID-19 IPAC procedures as per the home's Personal Protective Equipment (PPE) policy. Droplet/contact PPE use for three residents that required COVID-19 isolation precautions, were not followed by staff and a family visitor in accordance with Directive #3 and PHO best practices.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on July 14, 2021, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. A requirement was made for LTCHs to implement an isolation period under droplet and contact precautions for all residents with COVID-19 symptoms who had not been cleared of COVID-19. The purpose was to mitigate the potential risk related to variants of concern (VOC) and the potential of incubating COVID-19 infection. On July 14, 2021, the Directive emphasized that all LTCHs must implement and ensure ongoing compliance to the IPAC measures

outlined in the Directive. This included the Public Health Ontario (PHO) procedure for donning/doffing PPE and ensuring staff access to all PPE at point of care (POC).

Four residents had not been cleared for COVID-19 and required isolation measures under droplet/contact precautions of which two residents had specific symptoms.

Observations of PPE use for three of these residents showed the following:

A) Two staff members did not put on eye protection and take off their surgical masks after entering/exiting a resident's room and after performing direct care for the resident.

B) A family member/visitor was observed wearing PPE in the hallway, common area and dining room.They were in contact with multiple items. The family member/visitor did not wash their hands or put on a new gown prior to entering the room of a resident.

C) A staff member was observed with their goggles above their head when entering the same resident’s room. The staff member did not change their surgical mask when exiting.

D) A staff member entered the room of a resident and provided them a snack without putting on eye protection and taking off their surgical mask when exiting. PPE signage was not posted outside of the resident's room.

E) A resident who was under droplet and contact precautions was not isolated and was observed seated in one of the home's common areas.

F) There was no eye protection in the PPE carts outside of three resident rooms.

A Public Health (PH) representative stated that the home did not receive any guidance from PH that differed from Directive #3 and PHO best practices regarding PPE use.

An enteric outbreak was declared by Public Health (PH). The lack of IPAC precautions and not following best practices placed residents and staff at risk for disease transmission.

Sources: multiple observations (PPE use for three residents); progress notes (four residents), the home's policy Personal Protective Equipment (undated), Directives #3 (May 2021), PHO donning/doffing PPE (undated), Coronavirus Disease 2019

(COVID-19) Droplet and Contact Precautions Non-Acute Care Facilities (March 2020), Room Listing (July 2021); interviews the DONC, PH representatives and other staff members.

3. The licensee failed to ensure that Directive #3 and the Ministry of Health (MOH) COVID-19 Provincial Testing Guidance were followed regarding testing residents for COVID-19. Residents who had symptoms of COVID-19 and their roommates were to be tested for COVID-19 immediately.

A) Two residents were not tested immediately for COVID-19 as required.

B) Multiple staff were unaware of the testing and results. The home did not have a clear process for testing, obtaining the results and maintaining/documenting resident COVID-19 tests and results.

The lack of COVID-19 testing for the two residents placed residents and staff at minimal risk for infectious disease transmission.

Sources: progress notes and charts (two residents), a lab record, Directives #3 (May 2021), MOH COVID-19 Provincial Testing Guidance (September 2020); interviews the RN, NC, RAI-C, CN/RN, DONC and a PH representative.

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 O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the home developed and implemented a heat related illness prevention and management plan according to best practices.

Memorandum (memo) to LTC Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007, to help protect the safety and comfort of residents. A heat related illness prevention and management plan was to be developed and implemented. The plan was to be based on best practices which included resident risk factors, symptoms of heat related illness, resident assessments and individualized interventions in their plan of care, staff monitoring and a communication protocol which outlined how the home would communicate their heat related illness prevention and management plan to all residents, staff, volunteers, substitute decisionmakers (SDMs), visitors, and the resident and/or family councils. The plan was to be implemented by May 15, 2021, and on days when the outside temperature was 26 degrees Celsius or above.

On a date in July 2021, the outside temperature was 26 degrees Celsius. A cohesive heat related illness prevention and management plan had not been developed or implemented according to best practices as per the legislation and required timelines. Components of a plan were contained in the home's policies however, some components were missing and the criteria for temperature monitoring was not in accordance with the legislation. All residents, staff, volunteers, substitute decisionmakers (SDMs), visitors, and the resident and/or family councils had not been trained and/or informed as required.

The licensee not ensuring they had implemented a heat related illness prevention and management plan, which included the required communication protocol, was a potential risk to residents for heat related illness.

Sources: Memo to LTC Home Stakeholders: Amendments to O Reg. 79/10 under the LTCHA, 2007 related to enhanced cooling requirements (April 1, 2021), MLTC Cooling and Air Temperatures Requirements for LTCHs: A Summary of Changes (July 2021) with links to Centres for Disease Control and Prevention Warning Signs and Symptoms of Heat Related Illness (undated) and Health Canada Heat Alert and Response Systems to Protect Health: Best Practices Guidebook (2012), the weather network (July 29, 2021), the home’s policies: Heat Waves, Food Services (last reviewed March 2021), Heat Exhaustion, Nursing (last reviewed September 2020), Safe Outdoor Living (last reviewed January 2021), Extreme Hot and Cold Weather Conditions/Temperature (February 2021), and Hot Weather Illness Prevention Plan, Environmental (last reviewed October

2020); interviews with the DES and the DONC.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home develops and implements a heat related illness prevention and management plan according to best practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

The licensee has failed to ensure that temperatures were measured and documented in writing in at least two resident bedrooms in different parts of the home and in one common area on every floor of the home.

Memorandum to LTC Home (LTCH) Stakeholders dated April 1, 2021, advised of the changes to Ontario Regulation 79/10 under the LTCHA, 2007. Licensees were required to measure and document the air temperature, at a minimum, in certain specified areas in the LTC home at specified intervals as outlined in the legislation effective May 15, 2021.

From May 15 to June 31, 2021, the home had not taken temperatures in two resident bedrooms in different parts of the home and on both floors of the home. A contributing factor to this non-compliance was that the home’s environmental policy did not contain a procedure for measuring the temperatures as required per the legislation. The lack of measuring and documenting air temperatures as required was a risk the home may not identify when a heat related concern occurred. This could place residents at risk for heat related illness.

Sources: Memorandum to LTC Home (LTCH) Stakeholders: Amendments to O. Reg. 79/10 under the LTCHA, 2007 related to Enhanced Cooling (April 1, 2021), MLTC Cooling and Air Temperatures Requirements for LTCHs: A Summary of Changes (July 2021), the home's air temperature logs (May/June 2021), the home's Environmental policy Hot Weather Illness Prevention Plan-LTC Plan (October 2020); interviews with the DES and DONC.

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 temperatures are measured and documented in writing in at least two resident bedrooms in different parts of the home and in one common area on every floor of the home, to be implemented voluntarily.

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

Issued on this 27th day of August, 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) :	SHERRI COOK (633)
Inspection No. / No de l’inspection :	2021_610633_0014
Log No. / No de registre :	004739-21, 005383-21, 005384-21, 011418-21
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 18, 2021
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, Kitchener, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Riverside Glen 60 Woodlawn Road East, Guelph, ON, N1H-8M8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Bryce McBain

To Schlegel Villages Inc., 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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure:

1. That staff and resident hand hygiene is performed according to the Public Health Ontario (PHO) best practices including the Just Clean Your Hands Program and the moments of hand hygiene.

2. That all staff/visitors on two resident home areas (RHAs) are retrained to ensure compliance with staff/resident hand hygiene and donning/doffing personal protective equipment (PPE) for residents who require isolation precautions. A record of the training including the date, the person who provided the training, content and staff/visitor sign off must be maintained at the home.

3. A designated individual(s) conducts, at minimum, daily snack time audits on two RHAs to ensure compliance with staff/resident hand hygiene. The date of the audit, the person responsible, and the actions taken if any, must be documented for a minimum of three months.

4. All staff appropriately use PPE in accordance with the current Directive #3 and PHO best practices.

5. That all required PPE is at Point of Care (POC) according to best practices and/or Public Health (PH) guidance.

6. That appropriate PPE signage is posted for all residents that require isolation measures.

7. A designated individual(s) conducts, at minimum, daily audits on all shifts, on all affected resident home areas (RHAs) specific to staff PPE use for residents that require droplet and contact precautions to ensure compliance with Directive #3 and PHO best practices. The date of the audit, the person responsible, resident being audited and their isolation period, and the actions taken if any, must be documented for as long as the resident is on droplet/contact precautions.

8. That all symptomatic residents, and their roommates if any, are tested for COVID-19 in accordance with the current Directive #3 and testing guidance and/or PH guidance.

Grounds / Motifs :

1. The licensee has failed to ensure that staff fully participated in the implementation of the home's Infection Prevention and Control (IPAC) program in relation to performing hand hygiene for staff and residents.

The home's hand hygiene policy stated that the home participated in the Ontario's Just Clean Your Hands in Long Term-Care program which described when staff and resident hand hygiene should be completed.

Observations of staff/resident hand hygiene showed the following:

On three dates, on two resident home areas (RHAs), eight staff members did not perform hand hygiene as required and resident hand hygiene was not completed.

There was no hand hygiene signage posted on Eramosa RHA in the hallways, nurses station and lounge area to act as a reminder for staff and visitors.

Sources: Observations (two RHA's); the home's hand hygiene policy (undated), Just Clean Your Hands Long Term Care Keeping Residents Safe and Healthy (2011), Just Clean Your Hands Long Term Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition (April 2014), Coronavirus Disease 2019 (COVID-19); interviews with a PSW and a resident.

2. The licensee failed to ensure that all staff participated in the implementation of

the home's required COVID-19 IPAC procedures as per the home's Personal Protective Equipment (PPE) policy. Droplet/contact PPE use for three residents that required COVID-19 isolation precautions, were not followed by staff and a family visitor in accordance with Directive #3 and PHO best practices.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on July 14, 2021, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. A requirement was made for LTCHs to implement an isolation period under droplet and contact precautions for all residents with COVID-19 symptoms who had not been cleared of COVID-19. The purpose was to mitigate the potential risk related to variants of concern (VOC) and the potential of incubating COVID-19 infection. On July 14, 2021, the Directive emphasized that all LTCHs must implement and ensure ongoing compliance to the IPAC measures outlined in the Directive. This included the Public Health Ontario (PHO) procedure for donning/doffing PPE and ensuring staff access to all PPE at point of care (POC).

Four residents had not been cleared for COVID-19 and required isolation measures under droplet/contact precautions of which two residents had specific symptoms.

Observations of PPE use for three of these residents showed the following:

A) Two staff members did not put on eye protection and take off their surgical masks after entering/exiting a resident's room and after performing direct care for the resident.

B) A family member/visitor was observed wearing PPE in the hallway, common area and dining room.They were in contact with multiple items. The family member/visitor did not wash their hands or put on a new gown prior to entering the room of a resident.

C) A staff member was observed with their goggles above their head when entering the same resident's room. The staff member did not change their surgical mask when exiting.

D) A staff member entered the room of a resident and provided them a snack without putting on eye protection and taking off their surgical mask when exiting. PPE signage was not posted outside of the resident's room.

E) A resident who was under droplet and contact precautions was not isolated and was observed seated in one of the home's common areas.

F) There was no eye protection in the PPE carts outside of three resident rooms.

A Public Health (PH) representative stated that the home did not receive any guidance from PH that differed from Directive #3 and PHO best practices regarding PPE use.

An enteric outbreak was declared by Public Health (PH). The lack of IPAC precautions and not following best practices placed residents and staff at risk for disease transmission.

Sources: multiple observations (PPE use for three residents); progress notes (four residents), the home's policy Personal Protective Equipment (undated), Directives #3 (May 2021), PHO donning/doffing PPE (undated), Coronavirus Disease 2019 (COVID-19) Droplet and Contact Precautions Non-Acute Care Facilities (March 2020), Room Listing (July 2021); interviews the DONC, PH representatives and other staff members.

3. The licensee failed to ensure that Directive #3 and the Ministry of Health (MOH) COVID-19 Provincial Testing Guidance were followed regarding testing residents for COVID-19. Residents who had symptoms of COVID-19 and their roommates were to be tested for COVID-19 immediately.

A) Two residents were not tested immediately for COVID-19 as required.

B) Multiple staff were unaware of the testing and results. The home did not have a clear process for testing, obtaining the results and maintaining/documenting resident COVID-19 tests and results.

The lack of COVID-19 testing for the two residents placed residents and staff at minimal risk for infectious disease transmission.

Sources: progress notes and charts (two residents), a lab record, Directives #3 (May 2021), MOH COVID-19 Provincial Testing Guidance (September 2020); interviews the RN, NC, RAI-C, CN/RN, DONC and a PH representative.

An compliance order (CO) was made taking the following into account:

Severity: The licensee not ensuring that staff/visitor followed hand hygiene, droplet and contact precautions and COVID-19 resident testing was an actual risk for disease transmission.
Scope: This non-compliance was widespread as three of three residents reviewed regarding improper PPE use were impacted. Two of three RHAs were impacted regarding improper staff/resident hand hygiene and two of three residents reviewed were impacted related to improper COVID-19 testing.
Compliance History: The home had a previous voluntary plan of correction (VPC) issued December 12, 2018, during inspection 2018_610633_0021 to the same section of this legislation in the past 36 months.

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 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 18th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

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