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
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Jun 18, 2021	2021_792659_0012	003838-21, 003839-21, 006064-21, 006089-21	Critical Incident System

Licensee/Titulaire de permis

Saint Luke's Place
1624 Franklin Blvd. Cambridge ON N3C 3P4

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

Saint Luke's Place
1624 Franklin Boulevard Cambridge ON N3C 3P4

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

JANETM EVANS (659)

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): May 11, 12, 13, 14, 17, 18, 19, 20 and 21, 2021.

The following intakes were completed during this inspection:
Log #003839-21\ Follow up to CO#001 from inspection #2021_792659_0003 regarding doors in the home.
Log #003838-21\ Follow-up to CO#002 from inspection #2021_792659_0003 regarding reporting to the Director.
Log #006089-21\ Follow-up to CO#001 from inspection #2021_739694_0014 regarding protecting residents from abuse.
Log #006064-21\ Critical Incident System (CIS) report regarding a resident fall with injury.

This inspection was completed concurrently with complaint inspection #2021_792659_0013.

PLEASE NOTE: Written Notifications and Compliance orders related to LTCHA, 2011, s. 24 (1) and O. Reg. 79/10, s. 229 (4), were identified in a concurrent inspection #2021_792659_0013(Log #007107-21), and were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Assistant Director of Nursing/Infection Prevention and Control Lead (ADON/IPAC Lead), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),Health and Wellness/Fall Lead, Best Practice Coordinator, Behavioural Support Ontario (BSO) Lead, IPAC team members, Environmental Service Manager (ESM), Housekeepers Health Care Aides (HCA), Region of Waterloo Public Health Inspector and residents.

Observations were completed for IPAC practices, resident dining and snack service, staff to resident interactions, security of doors in the home and general care and cleanliness. A review of clinical records including but not limited to care plans, progress notes, assessments, risk management tools and relevant policies and procedures was completed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_739694_0014	659
O.Reg 79/10 s. 9. (1)	CO #001	2021_792659_0003	659

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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC) for the home.

(a) Signage was not posted outside a resident's room to identify that IPAC precautions were required.
The home's policy for IPAC signage, said the appropriate signage would be placed on the resident's door to alert staff and visitors of precautions to take.

(b) A resident had a fever and signage was posted related to required PPE precautions for staff when providing the resident care. Two staff provided care to the resident without following the posted precautions for PPE. A third staff was also observed exiting the resident's room without wearing the posted PPE precautions.

Waterloo Public Health confirmed the expectation was the home follow Directive #3 related to PPE use.

c) A resident had an infection and was on precautions which required staff wear specific PPE when providing care to the resident. Three staff transferred and provided care to the resident without wearing the recommended PPE. [753]

d) Direct care staff were observed transferring a resident using lift equipment. The resident had an infection and required isolation precautions. The lift equipment was not cleaned or disinfected after it was used to transfer the resident. In addition, there were no disinfectant wipes available for staff to use to clean and disinfect the equipment.

Waterloo Public Health stated that best practice included cleaning and disinfecting

equipment before and after resident use and as needed.[753]

e) An administrative staff member was observed walking from the surveillance area into the lounge area without donning a mask or eye protection. Directive #3 states that staff are required to comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas.[753]

f) Multiple visitors were observed entering the home and participating in COVID-19 surveillance screening. Clean PPE was not available directly at the entrance of the home, and visitors were not asked to don a new mask upon entering the home and prior to proceeding to the resident areas. Staff conducting the surveillance screening were not ensuring visitors were disinfecting their face shields prior to entering resident home areas.

Staff stated that they were not able to ensure that visitors were wearing a level two surgical mask. They also indicated that visitors were expected to disinfect their face shields prior to entering the resident home area with wipes provided by the home, however, there were no disinfectant wipes available for visitors to use in the surveillance area.

Waterloo Public Health stated that best practice included visitors donning a level two surgical mask, upon entering the building and donning a new shield provided by the home, or disinfecting their eye protection prior to going on a resident home area. [753]

Not following Directive #3 or best practice recommendations for IPAC put staff, residents and essential visitors at risk for disease transmission.

Sources: Observations, resident care plans, policy Additional Precautions and Signage, I-D-003, last reviewed January 2019, interviews with Waterloo Public Health, ADOC and other staff. [s. 229. (4)]

2. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices. Specifically, the home's hand hygiene program did not include hand hygiene procedures for residents in relation to snacks.

As per Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, staff are to encourage and assist residents to perform hand hygiene before and after snacks.

Over a five day period, staff provided residents with snacks, on three different units, but had not reminded, encouraged or assisted residents with hand hygiene prior to their snacks.

The ADOC/IPAC Lead acknowledged the home's IPAC policies did not specifically include procedures for resident hand hygiene.

By not following best practice for hand hygiene, staff and residents were at increased risk for disease transmission.

Sources: Observations, Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014, policy Hand hygiene - I-D 002, last revised January 2019, interview with staff and ADOC. [s. 229. (9)]

Additional Required Actions:

CO # - 001, 003 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. 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of a resident that resulted in harm was immediately reported, and the information upon which it was based, to the Director.

A resident required two staff assist for all transfers. On an identified date, the resident fell and sustained injuries while being assisted by one staff member to transfer and ambulate.

The home was immediately made aware of the improper care and the harm to the resident, however the incident was not reported to the Director until two days later.

There was minimal risk of harm to the resident resulting in the incident not being reported immediately to the Director.

Sources: CIS, resident's progress notes, the home's investigative notes, interviews with the DOC and other staff [753] [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the shower room door on lower level A was maintained in a safe condition and a good state of repair.

Observations completed May 11 – 19, 2021, showed a door to the shower room on unit A lower level was broken. There was tape across the door frame, the door was partially open and a note taped to the door said not to open the door.

An urgent work order task dated May 9, 2021, at 0828 hours, said the door was falling off the hinge and the door could not be secured. The work order also indicated the risk that the door was heavy and could fall on a resident.

A temporary shower room door was not installed to unit A lower level, until May 19, 2021, ten days later.

Sources: Observations, work order, interview with ESM and other staff [s. 15. (2) (c)]

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 is maintained in a safe condition and a good state of repair. Specifically, any doors on resident home units for any area/room a resident may use and would require staff supervision should be prioritized for repairs if needed, for resident safety, to be implemented voluntarily.

Issued on this 29th day of June, 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

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

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) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2021_792659_0012
Log No. / No de registre :	003838-21, 003839-21, 006064-21, 006089-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 18, 2021
Licensee / Titulaire de permis :	Saint Luke's Place 1624 Franklin Blvd., Cambridge, ON, N3C-3P4
LTC Home / Foyer de SLD :	Saint Luke's Place 1624 Franklin Boulevard, Cambridge, ON, N3C-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Toth

To Saint Luke's Place, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 s. 229 (4) of O. Reg. 79/10.
Specifically, the licensee must ensure that:
1) All staff, including Administrative, follow the IPAC guidance as set out in the Directives for the donning and doffing PPE, including universal masking.
2) Re -education of multiple staff members related to Public Health best practice guidance for PPE use when proving care to residents on isolation precautions. The training at a minimum should include the types of isolation, what to donn/doff, when to donn/doff, where to donn/doff the PPE. The training should be documented and include the date, the name of the person providing the training, the content reviewed and the name of the persons receiving the training.
4) All staff clean and disinfect lift equipment as per Public Health best practice guidance.
5) A designated individual(s) conducts, at minimum, daily audits on each unit and every shift to ensure compliance with donning and doffing PPE in accordance with isolation precaution signage, and cleaning and disinfecting lift equipment before and after use and as needed. The audits should continue for one month. The date of the audit, the person responsible, and the actions taken including disciplinary must be documented.
6) Registered staff review the resident's on isolation daily and ensure that the appropriate signage is posted for the type of precaution, as required.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program (IPAC) for the home.

(a) Signage was not posted outside a resident's room to identify that IPAC precautions were required.

The home's policy for IPAC signage, said the appropriate signage would be placed on the resident's door to alert staff and visitors of precautions to take.

(b) A resident had a fever and signage was posted related to required PPE precautions for staff when providing the resident care. Two staff provided care to the resident without following the posted precautions for PPE. A third staff was also observed exiting the resident's room without wearing the posted PPE precautions.

Waterloo Public Health confirmed the expectation was the home follow Directive #3 related to PPE use.

c) A resident had an infection and was on precautions which required staff wear specific PPE when providing care to the resident. Three staff transferred and provided care to the resident without wearing the recommended PPE. [753]

d) Direct care staff were observed transferring a resident using lift equipment. The resident had an infection and required isolation precautions. The lift equipment was not cleaned or disinfected after it was used to transfer the resident. In addition, there were no disinfectant wipes available for staff to use to clean and disinfect the equipment.

Waterloo Public Health stated that best practice included cleaning and disinfecting equipment before and after resident use and as needed.[753]

e) An administrative staff member was observed walking from the surveillance area into the lounge area without donning a mask or eye protection. Directive #3 states that staff are required to comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas.[753]

f) Multiple visitors were observed entering the home and participating in COVID-19 surveillance screening. Clean PPE was not available directly at the entrance of the home, and visitors were not asked to don a new mask upon entering the home and prior to proceeding to the resident areas. Staff conducting the surveillance screening were not ensuring visitors were disinfecting their face shields prior to entering resident home areas.

Staff stated that they were not able to ensure that visitors were wearing a level two surgical mask. They also indicated that visitors were expected to disinfect their face shields prior to entering the resident home area with wipes provided by the home, however, there were no disinfectant wipes available for visitors to use in the surveillance area.

Waterloo Public Health stated that best practice included visitors donning a level two surgical mask, upon entering the building and donning a new shield provided by the home, or disinfecting their eye protection prior to going on a resident home area. [753]

Not following Directive #3 or best practice recommendations for IPAC put staff, residents and essential visitors at risk for disease transmission.

Sources: Observations, resident care plans, policy Additional Precautions and Signage, I-D-003, last reviewed January 2019, interviews with Waterloo Public Health, ADOC and other staff. [s. 229. (4)]

An order was made taking the following factors into account:
Severity: There was potential risk to residents, staff and essential visitors of transmission of infectious agents.
Scope: The scope of this non-compliance was wide spread with management, staff, residents and essential visitors involved.
Compliance history: Three Written notifications (WN), 16 Voluntary Plans of Correction (VPC), eight Compliance orders (CO) and one Director Referral have been issued to the home related to different sections of the legislation in the past 36 months.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2021

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2021_792659_0003, CO #002;

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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

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

Specifically, the licensee must ensure:

1) That any person who has reasonable grounds to suspect that the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:

A) Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm.

2) All management of the home will review the requirements for critical incident reporting. A written record must be maintained at the home which includes the date of the review and who completed the review.

Grounds / Motifs :

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

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of a resident that resulted in harm was immediately reported, and the information upon which it was based, to the Director.

A resident required two staff assist for all transfers. On an identified date, the resident fell and sustained injuries while being assisted by one staff member to transfer and ambulate.

The home was immediately made aware of the improper care and the harm to the resident, however the incident was not reported to the Director until two days later.

There was minimal risk of harm to the resident resulting in the incident not being reported immediately to the Director.

Sources: CIS, resident's progress notes, the home's investigative notes, interviews with the DOC and other staff [753] [s. 24. (1)]

An order was made taking the following factors into account:
Severity: There was minimal risk to residents from the home not immediately reporting to the Director.
Scope: The scope of this non-compliance was isolated with one of three incidents reviewed a concern.
Compliance history: The licensee was found to be in noncompliance with different sections of the legislation in the past 36 months.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2021

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Order / Ordre :

The licensee must be compliant with s. 229 (9) of O. Reg. 79/10.
Specifically, the licensee must ensure that:
1) The licensee will review and revise their hand hygiene policy to include best practices for residents; including hand hygiene before and after meals and snacks.
2) All staff will be trained on the new hand hygiene policy.
3) A documented record of the training, including who provided the training, the date of the training and staff members that attended the training is to be kept in the home.
3) At a minimum, weekly audits will be conducted on each unit for resident hand hygiene, to ensure compliance with the revised policy. The audits will continue for a minimum of two months or until no further concerns are identified related to resident hand hygiene. The audit should include: the date and time, the person responsible, the findings and any action taken.

Grounds / Motifs :

1. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices. Specifically, the home's hand hygiene program did not include hand hygiene procedures for residents in relation to snacks.

As per Public Health Ontario, Just Clean Your Hands Long-Term Care Home Implementation Guide, staff are to encourage and assist residents to perform hand hygiene before and after snacks.

Over a five day period, staff provided residents with snacks, on three different units, but had not reminded, encouraged or assisted residents with hand hygiene prior to their snacks.

The ADOC/IPAC Lead acknowledged the home's IPAC policies did not specifically include procedures for resident hand hygiene.

By not following best practice for hand hygiene, staff and residents were at increased risk for disease transmission.

Sources: Observations, Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014, policy Hand hygiene - I-D 002, last revised January 2019, interview with staff and ADOC. [s. 229. (9)]

An order was made taking the following factors into account:
Severity: There was minimal risk to residents from the home not immediately reporting to the Director.
Scope: The scope of this non-compliance was widespread with three of four resident home areas observed not completing the required hand hygiene with residents.
Compliance history: Three Written notifications (WN), 16 Voluntary Plans of Correction (VPC), eight Compliance orders (CO) and one Director Referral have been issued to the home related to different sections of the legislation in the past 36 months. (659)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 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 June, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : JanetM Evans

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