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

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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
Feb 10, 2020	2020_543561_0001	015580-19, 016082-19, 018043-19, 019902-19, 020866-19, 023322-19, 023530-19, 023794-19, 024354-19, 000289-20	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Wentworth Lodge
41 South Street West DUNDAS ON L9H 4C4

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)

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): January 9, 13, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 2020.

A Follow Up (FU) Inspection to Order #001 related to s. 19(1), with a log #015580-19, was completed concurrently with this Inspection.

The following Critical Incident (CI) Inspections with the following log numbers were completed during this inspection:

016082-19, CI #M592-000036-19 - related to a fall with injury,
018043-19, CI #M592-000041-19 - related to a fall with injury,
019902-19, CI #M592-000045-19 - related to a medication incident,
020866-19, CI #M592-000052-19 - related to resident to resident abuse,
023322-19, CI #M592-000064-19 - related to resident to resident abuse,
023530-19, CI #M592-000067-19 - related to resident to resident abuse,
023794-19, CI #M592-000070-19 - related to resident to resident abuse,
024354-19, CI #M592-000072-19 - related to resident to resident abuse,
000289-20, CI #M592-000001-20 - related to staff to resident abuse,

A Complaint Inspection number 2020_560632_002, was also conducted concurrently with this CI Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers, Social Worker (SW), Resident Assessment Instrument (RAI) / Minimum Data System (MDS) Restorative Care Coordinator, Infection Control Practitioner, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s): toured the home, observed provision of care, reviewed clinical records, reviewed investigation notes, reviewed policies and procedures, training records and program evaluations.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

Long Term Care Homes Act, (LTCHA), 2007, O. Reg. 79/10, includes types of abuse and their definitions.

A) A CIS report was submitted to the Director alleging resident #019 was abused by RPN #140.
Review of resident #019's plan of care, identified that resident #019 had a specified diagnosis and an identified Cognitive Performance Scale (CPS) score. The resident's plan of care included interventions related to the resident's specified health condition.

Investigation notes and clinical records were reviewed and indicated that on an identified date in 2020, there was an incident between resident #019 and RPN #140.

Resident #019 was interviewed and confirmed what had occurred on the day of the identified incident with RPN #140. The Social Worker was interviewed and indicated that on the same day resident #019 complained to them about RPN #140. During the inspection, RPN #140 was interviewed and described the incident as it was reported and documented in the investigation notes and CIS report. Interviews with PSW #141 and PSW #139 who witnessed the incident, stated that it caused the resident to be upset. RN #127, was also interviewed and confirmed the incident occurred and had a negative impact on the resident.

The DON acknowledged that, resident #019 was not protected from abuse by RPN #140's actions.

The home did not ensure that resident #019 was protected from abuse by RPN #140. (632)

B) A CIS report was submitted to the Director, which indicated that resident #003 had an altercation with resident #002 on an identified date in 2019 which resulted in injury to resident #002.
Clinical record review indicated that resident #002 sustained an injury due to the altercation with resident #003 on an identified date in 2019.

Registered staff #125 was interviewed and confirmed the incident that occurred on the identified date towards resident #002. They also stated that resident #003 had a history of responsive behaviour.

The Nurse Manager #2 was interviewed and stated that resident #003's actions were abusive towards resident #002.

C) A CIS report was submitted to the Director on an identified date in 2019, which described an incident where resident #013's actions caused an injury to resident #014. Clinical record review described the incident that occurred between resident #014 and #013 causing an injury to resident #014.

Registered staff #128 was interviewed and stated that they witnessed the incident and immediately intervened.
Interviews with PSWs #124, PSW #107 and registered staff #138 indicated that resident #013 had a history of responsive behaviour.

D) A CIS report was submitted to the Director on an identified date in 2019, indicating that resident #013 had an incident causing an injury to resident #015.
Progress notes indicated that resident #013 demonstrated responsive behaviour towards resident #015 causing an injury. Staff immediately intervened.

Registered staff #131 was interviewed and identified triggers for the responsive behaviour of resident #013 and confirmed during this incident this is what triggered the resident's behaviour. The Nurse Manger #2 confirmed the actions of resident #013 caused injury to resident #015.

E) A CIS report was submitted to the Director on an identified date in 2019, which indicated that resident #013 had an incident which caused injury to resident #016.
Progress notes were reviewed and the documentation described the identified incident towards resident #016 causing injury.

Registered staff #138 was interviewed and stated that resident #013's actions caused an injury towards resident #016.

Interviewed Nurse Manager #2 and they stated that resident #013 abused resident #014, #015 and #016. All residents sustained injuries as a result.

The licensee failed to ensure that residents #019, #002, #014, #015, and #016 were protected from abuse by anyone. [s. 19. (1)]

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying factors, based on interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions.

A) Clinical record review and a review of a CIS report submitted to the Director, indicated that resident #013 had several incidents of abuse towards residents #014, #015 and #016 causing injuries in 2019.

Review of the progress notes identified that resident #013 was being followed by Behavioural Support Ontario (BSO) nurse and was discharged from the program on an identified date prior to these incidents in 2019. The progress note; however, indicated that if the resident would have any additional responsive behaviours or new behaviours the staff should send a new referral to BSO. The home's process, as indicated through interviews with registered staff #131, #125, and the Nurse Manager, was to refer residents to BSO after an incident of altercation.

Clinical record review did not include BSO referrals after two of the incidents that

occurred in 2019. Social Worker (SW) was interviewed and indicated that the process of referrals to BSO was that the staff would send a referral to the SW and then they would fax the referral to BSO. SW confirmed that the referrals were not sent to them after these incidents.

The plan of care for resident #013, identified a trigger for resident's behaviour. The plan of care and an interview with the Nurse Manager/Lead for Responsive Behaviour Program, indicated that the home put in place interventions after each of the identified incidents; however, they were either not followed or were in the process of being implemented. After the third incident the home implemented an identified closer monitoring of resident #013.

B) Clinical record review and a CIS report submitted to the Director indicated that on an identified date in 2019, resident #003 had an altercation towards resident #002 that resulted in injury.

Progress notes were reviewed and indicated that resident #003 was discharged from BSO prior to the incident; however, the staff were to send a new referral in case of any new responsive behaviour displayed by the resident. Clinical record review identified that no BSO referrals were sent after the identified incident.
Interviewed the SW and they indicated that they did not receive a referral from staff to refer the resident to BSO.

C) Interviews with registered staff #112, #125, #131 and #138 indicated that the home was using an assessment tool called a Behavioural and Psychological Symptoms of Dementia Assessment (BPSD) to assess residents' behaviours and identify interventions. This tool was to be completed after each incident of responsive behaviours.

The home's policy titled "Managing and Accommodating Responsive Behaviours", revised 2019, indicated that the assessment of responsive behaviours will be achieved through a variety of formal and informal processes, one of them being Behavioural and Psychological Symptoms of Dementia Assessment (BPSD) Assessment in Point Click Care (PCC).

i) Resident #013 had an incident on an identified date in 2019, causing injury to resident #014. Clinical records were reviewed and indicated that the BPSD assessment was not completed after the incident.

ii) On an identified date in 2019, resident #002 had an altercation towards resident #011. Resident #011 sustained an injury as a result. Clinical record review identified that the BPSD assessment was not completed after the incident.

iii) On an identified date in 2019, resident #002 and resident #003 had an altercation and both residents sustained injuries. Clinical record review indicated that the BPSD assessment was not completed after the incident.

The Nurse Manager/Lead for Responsive Behaviours Program was interviewed and confirmed that the BPSD assessments were not completed after each of the identified incidents.

The home failed to ensure that steps were taken including referring residents #003 and #013 to BSO after numerous incidents of aggression and completing the BPSD assessments to minimize harmful interactions between and among residents including identifying and implementing interventions. [s. 54.]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying factors, based on interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions, to be implemented voluntarily.

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 comply with s. 24. (1) 2 in that a person, who had reasonable grounds to suspect abuse of a resident failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA. Pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1).

A CIS report was submitted to the Director alleging staff #140 abused resident #019. Investigation notes and clinical records were reviewed and indicated that on an identified date in 2020, RPN 140 was abusive towards resident #019 which made the resident upset.

During the inspection, resident #019 was interviewed and stated that RPN #140 was abusive towards them. RPN #140 was interviewed during the inspection confirming the incident. RN #127, witnessed the incident and confirmed that it was not reported to the Director immediately since they wanted to discuss the incident with the NM #1 first.

Interview with PSW #141, who was present during the incident, indicated that they did not report this incident immediately to the registered staff or the management and they planned to do it the next morning.

Review of the home's Resident Related Policy NO: AM-06-06 "Prevention, Reporting & Elimination of Abuse of Residents of LTC Homes" (date reviewed: December 21, 2019), which stated that abuse of a resident by anyone resulted in a risk of harm was to be immediately reported upon becoming aware of the incident and immediately notify MLTC by phoning Service Ontario After Hours line phone number and submit the CIS report the next business day.

The DON acknowledged that this incident was not immediately reported to the MLTC.

The home failed to ensure that a person a person, who had reasonable grounds to suspect abuse of resident #019, failed to report the alleged abuse immediately to the Director in accordance with s. 24. (1) 2 of the LTCHA, pursuant to s. 152. (2) the licensee was vicariously liable for staff members failing to comply with subsection 24. (1). [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was created and maintained for each resident of the home.

A) Review of the plan of care identified that resident #017 had an unwitnessed fall on an identified date in 2019, and sustained an injury.

Review of the progress notes, identified the Head Injury Routine (HIR) was initiated in the post fall assessment and on day shift, it was documented that the HIR was maintained and vitals were within normal ranges. On the evening shift it was documented by registered staff that the resident was on the HIR and vital signs were stable and recorded.

Following a review of the plan of care during an interview with Nurse Manager #2, they stated the registered staff documented that the HIR was being completed; however, confirmed that they were unable to find the HIR record in the resident's plan of care.

The written record for the HIR post fall, was not maintained for resident #017. (581)

B) Clinical record review for resident #013 indicated that the resident had an altercation towards resident #015 causing an injury on an identified dated in 2019. Clinical records also indicated that resident was on DOS monitoring. Resident #013 had another altercation towards resident #014 on an identified date in 2019 causing an injury to resident #014. Progress notes indicated that the resident was already on DOS monitoring. The registered staff #125 indicated that DOS monitoring was completed on paper. Resident #013's chart was reviewed, and DOS monitoring could not be found. The Nurse Manager #2 was interviewed and stated that the home kept DOS monitoring

sheets in a chart; however, was not able to locate them. The DON indicated that the home was not able to find the records of DOS monitoring for this resident.

C) Clinical record review for resident #003 indicated that the resident had an altercation with resident #002 that caused an injury to resident #002 on an identified date in 2019. Progress notes indicated that resident #003 was on DOS monitoring. Resident #003 and resident #002 had an altercation on another date in 2019, and the progress notes indicated that resident #003 was already on DOS monitoring. Resident #003's chart was reviewed and DOS monitoring sheets could not found. The DON indicated that the home was not able to locate DOS monitoring sheets for resident #003.

The licensee failed to ensure that, a written record of DOS charting was maintained for resident #003 and #013 in the home. [s. 231. (a)]

Issued on this 11th day of February, 2020

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) :	DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)
Inspection No. / No de l’inspection :	2020_543561_0001
Log No. / No de registre :	015580-19, 016082-19, 018043-19, 019902-19, 020866-19, 023322-19, 023530-19, 023794-19, 024354-19, 000289-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 10, 2020
Licensee / Titulaire de permis :	City of Hamilton 28 James Street North, 4th Floor, HAMILTON, ON, L8R-2K1
LTC Home / Foyer de SLD :	Wentworth Lodge 41 South Street West, DUNDAS, ON, L9H-4C4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Karen Allcroft

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 City of Hamilton, 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: 2019_573581_0005, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with Long Term Care Homes Act, 2007, s. 19(1).

Specifically the licensee shall ensure that:

1. Resident #019 and any other resident in the home are protected from abuse by staff or anyone.
2. Resident #002, #014, #015, #016 and any other resident in the home are protected from abuse by resident #003 and #013.

Grounds / Motifs :

1. The licensee failed to comply with the following compliance order CO#001 from inspection #2019_573581_0005 issued on July 12, 2019, with a compliance date of October 11, 2019.

The licensee was ordered to ensure the following:
a) Resident #001, #003, #004, #005, #006, #009, #011 (in this inspection residents #008, #009, #012, #010, #011, #007, #003) and all other residents, be protected from abuse by resident #002 and #010 (in this inspection residents #005 and #004).
b) Resident #002 and #010 (in this inspection residents #005 and #004), and all other residents, that are known to staff to demonstrate responsive behaviours, have interventions in place to monitor the resident(s) for their behaviours and interventions are implemented to protect other residents from abuse.
c) All staff receive training on the definition of abuse and the licensee's policy on

mandatory reporting of any alleged, suspected or witnessed abuse.

The licensee completed step (b) and (c) of the order.

The licensee failed to ensure that residents were protected from abuse by anyone.

Long Term Care Homes Act, (LTCHA), 2007, O. Reg. 79/10, includes types of abuse and their definitions.

A) A CIS report was submitted to the Director alleging resident #019 was abused by RPN #140.

Review of resident #019's plan of care, identified that resident #019 had a specified diagnosis and an identified Cognitive Performance Scale (CPS) score. The resident's plan of care included interventions related to the resident's specified health condition.
Investigation notes and clinical records were reviewed and indicated that on an identified date in 2020, there was an incident between resident #019 and RPN #140.

Resident #019 was interviewed and confirmed what had occurred on the day of the identified incident with RPN #140. The Social Worker was interviewed and indicated that on the same day resident #019 complained to them about RPN #140. During the inspection, RPN #140 was interviewed and described the incident as it was reported and documented in the investigation notes and CIS report. Interviews with PSW #141 and PSW #139 who witnessed the incident, stated that it caused the resident to be upset. RN #127, was also interviewed and confirmed the incident occurred and had a negative impact on the resident.

The DON acknowledged that, resident #019 was not protected from abuse by RPN #140's actions.

The home did not ensure that resident #019 was protected from abuse by RPN #140. (632)

B) A CIS report was submitted to the Director, which indicated that resident

#003 had an altercation with resident #002 on an identified date in 2019 which resulted in injury to resident #002.
Clinical record review indicated that resident #002 sustained an injury due to the altercation with resident #003 on an identified date in 2019.

Registered staff #125 was interviewed and confirmed the incident that occurred on the identified date towards resident #002. They also stated that resident #003 had a history of responsive behaviour.

The Nurse Manager #2 was interviewed and stated that resident #003's actions were abusive towards resident #002.

C) A CIS report was submitted to the Director on an identified date in 2019, which described an incident where resident #013's actions caused an injury to resident #014.
Clinical record review described the incident that occurred between resident #014 and #013 causing an injury to resident #014.

Registered staff #128 was interviewed and stated that they witnessed the incident and immediately intervened.
Interviews with PSWs #124, PSW #107 and registered staff #138 indicated that resident #013 had a history of responsive behaviour.

D) A CIS report was submitted to the Director on an identified date in 2019, indicating that resident #013 had an incident causing an injury to resident #015.
Progress notes indicated that resident #013 demonstrated responsive behaviour towards resident #015 causing an injury. Staff immediately intervened.

Registered staff #131 was interviewed and identified triggers for the responsive behaviour of resident #013 and confirmed during this incident this is what triggered the resident's behaviour. The Nurse Manger #2 confirmed the actions of resident #013 caused injury to resident #015.

E) A CIS report was submitted to the Director on an identified date in 2019, which indicated that resident #013 had an incident which caused injury to resident #016.
Progress notes were reviewed and the documentation described the identified

incident towards resident #016 causing injury.

Registered staff #138 was interviewed and stated that resident #013's actions caused an injury towards resident #016.

Interviewed Nurse Manager #2 and they stated that resident #013 abused resident #014, #015 and #016. All residents sustained injuries as a result.

The licensee failed to ensure that residents #019, #002, #014, #015, and #016 were protected from abuse by anyone.

The severity of this issue was determined to be level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to five of six residents reviewed. The home had a level three history of on-going non-compliance with this subsection of the Act that included:
- A Compliance Order (CO) issued on July 12, 2019 (2019_573581_0005).
Additionally, the LTCH has a history of a Director's Order (DO) issued in the last 36 months. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2020

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 10th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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