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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2022	2021_885601_0024 (A1)	014302-21	Director Order Follow Up

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive Peterborough ON K9K 2R8

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

St. Joseph's at Fleming
659 Brealey Drive Peterborough ON K9K 2R8

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

Amended by KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection report has been revised to reflect the request to amend the compliance order due date to April 22, 2022, for the Director Order Follow up inspection #2021_885601_0024. A copy of the revised report is attached.

Issued on this 25th day of March, 2022 (A1)

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

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

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659 Brealey Drive Peterborough ON K9K 2R8

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

Amended by KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Director Order Follow Up inspection.

This inspection was conducted on the following date(s): December 2, 3, 6, 7, 8, 9, 10, 14, and 15, 2021.

A follow up inspection to a Director Order (DO#001 served on 2021-09-09) has concluded that the Director Order was not complied with. An Inspector's Order (CO#001) has been issued for the same non-compliance (r. 229. (4)).

A log related to Director Order Follow Up for DO# 001 regarding infection prevention and control measures.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Infection Prevention and Control (IPAC) lead, Director of Resident Care (DRC), Home Area Manager (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide (HSK) Dietary Aide (DA), Public Health Inspector, and residents.

A follow up inspection to a Director Order (DO#001 served on 2021-09-09) has concluded that the Director Order was not complied with. An Inspector's Order (CO#001) has been issued for the same non-compliance (r. 229. (4)).

The inspector also reviewed resident clinical health care records, relevant home policies and procedures, respiratory infection line listing, observed infection control practices in the home, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Personal Support Services

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

2 WN(s)
0 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 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to detecting a respiratory outbreak, isolation signage, the use of personal protective equipment (PPE), hand hygiene (HH).

Inspector #111 conducted inspection #2021_887111_0012 at St. Joseph's at Fleming Nursing Home. Inspector #111 issued non-compliance with O. Reg 79/10, s. 229(4) and CO #001 was issued with a compliance due date of September 30, 2021. An appeal was received and Director Review (DR) #154 was completed. On September 8, 2021, CO #001 was rescinded and Director Order (DO) #001 was issued regarding non-compliance with O. Reg 79/10, s. 229(4), with a compliance due date of September 30, 2021. DO #001 directed the home to conduct daily audits in all home areas for a two-week period, especially those residents on droplet and/or contact precautions, to ensure all staff, essential visitors, support staff were adherent to the appropriate Infection Prevention and Control (IPAC) practices. In addition, on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures was to be completed.

Observation of the isolation signage for four residents identified that staff failed to ensure that appropriate signage for additional precautions was posted. The IPAC lead acknowledged the isolation signage on the residents' bedroom doors did not reflect the actual additional precautions for PPE that were in place for the residents.

A Housekeeper (HSK) was observed cleaning a resident's room, who required contact precautions as per the sign on their bedroom door. The HSK was wearing a mask and gloves but no gown when they were cleaning the room and their

uniform was observed to touch the resident's bedside table. The long-term care home's IPAC program included requirements for staff to wear gloves and a gown for activities that involve direct care or when clothing may come in direct contact with the resident's items in the resident's room or bed space with contact precautions in place. The program specified that PPE was to be removed, and hands cleaned immediately following the activity for which they were used. The HSK indicated that they had not used all the required PPE when they cleaned the resident's bathroom and bedroom. They further indicated they were not aware that they were required to wear a gown when cleaning a resident's environment that required contact precautions. The IPAC lead indicated that the HSK had received education on the use of PPE while cleaning and should have worn a gown when cleaning the resident's environment that was on contact precautions. The HSK failed to participate in the implementation of the IPAC program which presented actual risk of spreading infection when the HSK did not wear a gown while cleaning the resident's environment and when their uniform touched the resident's bedside table.

Several staff were observed to touch their mask and staff were observed to have their mask not covering their mouth and nose. Staff observed did not perform HH before and after touching their surgical mask. Staff confirmed they had received IPAC education and staff should perform HH when they were donning or doffing their surgical mask. The IPAC lead indicated that all staff received education on "Just Clean Your Hands - Your4 Moments for Hand Hygiene" program. According to the IPAC lead, staff received on the spot IPAC education when staff were observed to have not followed the IPAC procedures for donning, doffing of PPE and HH. The IPAC lead further indicated they had analyzed the results of the donning and doffing of PPE and HH audits completed and the results identified several staff were not compliant with the IPAC procedures and that ongoing education was required.

The residents were at actual risk for transmission of infection when staff failed to detect the respiratory outbreak in a timely manner and ensure that appropriate signage was posted, staff did not properly don PPE, nor did staff consistently perform HH when touching their mask that was worn for universal precautions.

Sources: Observations of a HSK, signage on resident bedroom doors, clinical record review for several residents, review of the home's Contact Precaution policy, Charge Nurse Shift Reports, Respiratory Outbreak Line Listing Form, Compliance Audits, interviews with HSK, PSW, RPN, and the IPAC Lead. [s. 229.

(4)]

2. The licensee has failed to ensure that staff recorded resident #013's symptoms of infection on every shift.

The resident's physician prescribed an antibiotic for the resident to treat an infection. Review of the resident's progress notes identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for an infection. There was no documentation in the resident's progress notes on every shift to indicate that the resident's infection was assessed or if the treatment was effective. The Infection Prevention and Control (IPAC) lead indicated they were not aware if the resident's infection was resolved following the antibiotic treatment. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's infection.

Sources: Review of the resident's care plan, physician orders, progress notes, Medication Administration Record, interviews with registered staff and the IPAC lead.

3. The licensee has failed to ensure that staff recorded resident #017's symptoms of infection on every shift.

The resident physician prescribed an antibiotic for the resident to treat an infection. Review of the resident's progress notes identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for the infection. There was no documentation in the resident's progress notes on every shift to indicate that the resident's infection was assessed or if the treatment was effective. The Infection Prevention and Control (IPAC) lead indicated they were not aware if the resident's infection was resolved following the antibiotic treatment. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's

infection.

Sources: Review of the resident's care plan, physician orders, progress notes, Medication Administration Record, interviews with registered staff and the IPAC lead.

4. The licensee has failed to ensure that staff recorded a resident #018's symptoms of infection on every shift.

The resident's Nurse Practitioner prescribed an antibiotic for the resident to treat an infection. Review of the resident's progress notes identified staff did not record if the resident was symptomatic of infection on every shift while the resident was being treated for an infection. There was no documentation in the resident's progress notes on every shift to indicate that the resident's infection was assessed or if the treatment was effective. The Infection Prevention and Control (IPAC) lead indicated they were not aware if the resident's infection was resolved following the antibiotic treatment. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the antibiotic was effective in treating the resident's infection.

Sources: Review of the resident's care plan, physician orders, progress notes, Medication Administration Record, interviews with registered staff and the IPAC lead.

5. The licensee has failed to ensure that staff recorded resident #021's symptoms of infection on every shift.

The resident was placed on isolation precautions due to being symptomatic of an infection. Review of the resident's progress notes identified staff did not record if the resident was symptomatic of an infection on every shift while the resident was on precautionary isolation for an infection. There was no documentation in the resident's progress notes on every shift to indicate that the resident's infection was assessed or if the resident's condition was improving. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infection was not assessed, and

symptoms were not recorded on every shift to determine if the resident's health status was improving.

Sources: Review of the resident's care plan, progress notes, interviews with registered staff and the IPAC lead.

6. The licensee has failed to ensure that staff recorded resident #005's symptoms of infection on every shift.

The resident was placed on isolation precautions due to being symptomatic of an infection. The Nurse Practitioner prescribed an antibiotic for the resident to treat a potential medical condition. Review of the resident's progress notes identified staff did not record if the resident was symptomatic of infection on every shift while the resident was on precautionary isolation for an infection. There was no documentation in the resident's progress notes on every shift to indicate that the resident's infection was assessed or if the resident's condition was improving. Registered staff acknowledged they did not assess symptoms of infection on every shift, and they should record symptoms of infection in the resident's progress notes. The resident was at risk for discomfort when the resident's infection was not assessed, and symptoms were not recorded on every shift to determine if the resident's health status was improving.

Sources: Review of the resident care plan, progress notes, Medication Administration Record, interviews with registered staff and the IPAC lead. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure the home's Infection Prevention and Control policy was complied with related to the reporting protocols based on the requirements of the Health Protection and Promotion Act when the Public Health Unit (PHU) was not made aware that a resident was the initial resident to be symptomatic for a respiratory infection.

A Resident was symptomatic for a respiratory infection during the same time frame as two other residents and they were not included in the home's respiratory outbreak that was declared by the Public Health Unit (PHU). The IPAC lead indicated that all three residents reside on the same home area and their respiratory symptoms were documented on the charge nurse shift report used to track and identify trends for infections. The IPAC lead indicated the PHU was first contacted to report that the other two residents were experiencing more than two respiratory symptoms at the same time. The IPAC lead indicated that the resident's symptoms would have met the case definition for the respiratory outbreak, and they couldn't explain the reason why the resident was not included on the respiratory outbreak line listing form provided to the PHU. According to the IPAC lead, the respiratory outbreak was declared a few days after the resident was identified to be symptomatic with a respiratory infection. A delay in detecting the respiratory outbreak and notifying the PHU of residents who were symptomatic for a respiratory infection could lead to a potential increase of transmission of infectious conditions.

Sources: Clinical record review for three residents, Infection Control Prevention Droplet Policy, Charge Nurse Shift Reports, Respiratory Outbreak Line Listing Form, "Ministry of Health and Long-Term Care - Control of Respiratory Infection Outbreaks in Long Term Care Homes", interviews with the IPAC Lead. [s. 8. (1)]

Issued on this 25th day of March, 2022 (A1)

[redacted]

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by KARYN WOOD (601) - (A1)
Inspection No. / No de l’inspection :	2021_885601_0024 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014302-21 (A1)
Type of Inspection / Genre d’inspection :	Director Order Follow Up
Report Date(s) / Date(s) du Rapport :	Mar 25, 2022(A1)
Licensee / Titulaire de permis :	St. Joseph's at Fleming 659 Brealey Drive, Peterborough, ON, K9K-2R8
LTC Home / Foyer de SLD :	St. Joseph's at Fleming 659 Brealey Drive, Peterborough, ON, K9K-2R8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Carol Rodd

To St. Joseph's at Fleming, 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: 2021_887111_0012, DO #001;

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 section s. 229. (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure appropriate signage is in place at the entrance to residents' rooms where staff are required to utilize additional personal protective equipment (PPE).

2. Audit staff compliance to the proper technique for donning and doffing of PPE and Hand Hygiene (HH) daily every shift until all staff have been audited and can demonstrate proper technique consistently. Keep a documented record of all staff that were audited.

3. Analyze the results of the audits and provide further education to any staff who did not adhere to the proper technique for donning and doffing of PPE and HH. Keep a documented record of the staff that required further education and continue audits for the staff identified until the staff member has achieved compliance.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to detecting a respiratory outbreak, isolation signage, the use of personal protective equipment (PPE), hand hygiene (HH).

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

Inspector #111 conducted inspection #2021_887111_0012 at St. Joseph's at Fleming Nursing Home. Inspector #111 issued non-compliance with O. Reg 79/10, s. 229(4) and CO #001 was issued with a compliance due date of September 30, 2021. An appeal was received and Director Review (DR) #154 was completed. On September 8, 2021, CO #001 was rescinded and Director Order (DO) #001 was issued regarding non-compliance with O. Reg 79/10, s. 229(4), with a compliance due date of September 30, 2021. DO #001 directed the home to conduct daily audits in all home areas for a two-week period, especially those residents on droplet and/or contact precautions, to ensure all staff, essential visitors, support staff were adherent to the appropriate Infection Prevention and Control (IPAC) practices. In addition, on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures was to be completed.

Observation of the isolation signage for four residents identified that staff failed to ensure that appropriate signage for additional precautions was posted. The IPAC lead acknowledged the isolation signage on the residents' bedroom doors did not reflect the actual additional precautions for PPE that were in place for the residents.

A Housekeeper (HSK) was observed cleaning a resident's room, who required contact precautions as per the sign on their bedroom door. The HSK was wearing a mask and gloves but no gown when they were cleaning the room and their uniform was observed to touch the resident's bedside table. The long-term care home's IPAC program included requirements for staff to wear gloves and a gown for activities that involve direct care or when clothing may come in direct contact with the resident's items in the resident's room or bed space with contact precautions in place. The program specified that PPE was to be removed, and hands cleaned immediately following the activity for which they were used. The HSK indicated that they had not used all the required PPE when they cleaned the resident's bathroom and bedroom. They further indicated they were not aware that they were required to wear a gown when cleaning a resident's environment that required contact precautions. The IPAC lead indicated that the HSK had received education on the use of PPE while cleaning and should have worn a gown when cleaning the resident's environment that was on contact precautions. The HSK failed to participate in the implementation of the IPAC program which presented actual risk of spreading infection when the HSK did not wear a gown while cleaning the resident's environment and when their uniform touched the resident's bedside table.

Several staff were observed to touch their mask and staff were observed to have their mask not covering their mouth and nose. Staff observed did not perform HH before and after touching their surgical mask. Staff confirmed they had received IPAC education and staff should perform HH when they were donning or doffing their surgical mask. The IPAC lead indicated that all staff received education on "Just Clean Your Hands - Your4 Moments for Hand Hygiene" program. According to the IPAC lead, staff received on the spot IPAC education when staff were observed to have not followed the IPAC procedures for donning, doffing of PPE and HH. The IPAC lead further indicated they had analyzed the results of the donning and doffing of PPE and HH audits completed and the results identified several staff were not compliant with the IPAC procedures and that ongoing education was required.

The residents were at actual risk for transmission of infection when staff failed to detect the respiratory outbreak in a timely manner and ensure that appropriate signage was posted, staff did not properly don PPE, nor did staff consistently perform HH when touching their mask that was worn for universal precautions.

Sources: Observations of a HSK, signage on resident bedroom doors, clinical record review for several residents, review of the home's Contact Precaution policy, Charge Nurse Shift Reports, Respiratory Outbreak Line Listing Form, Compliance Audits, interviews with HSK, PSW, RPN, and the IPAC Lead.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program. Specifically, staff did not adhere to the proper donning of PPE, and hand hygiene practices.

Scope: The scope of this non-compliance was a pattern as one staff failed to adhere to safely don Personal Protective Equipment (PPE) and Hand hygiene (HH) was not performed by several staff and the HH deficiencies noted affected four out of the eight resident home areas.

Compliance History: One previous Compliance Order that was amended and

replaced with a Director Order and a Voluntary Plans of Correction was issued to the home under the same subsection of the legislation within the previous 36 months. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 22, 2022(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 25th day of March, 2022 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KARYN WOOD (601) - (A1)

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

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