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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jan 24, 2022	2022_968920_0002	013005-21, 019730-21	Critical Incident System

Licensee/Titulaire de permis

Haldimand War Memorial Hospital
400 Broad Street West Dunnville ON N1A 2P7

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

Edgewater Gardens Long Term Care Centre
428 Broad Street West Dunnville ON N1A 1T3

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

BARBARA GROHMANN (720920), LISA VINK (168)

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 6-7, 10-12, 2022.

The following intakes were completed in this Critical Incident (CI) inspection:
Log # 013005-21, related to falls management.
Log # 019730-21, related to medication administration.

PLEASE NOTE: A Written Notification related to Long-Term Care Homes Act (LTCHA) chapter (c.) 8, section (s.) 6 (7) was identified in this inspection and has been issued in Inspection Report 2022_968920_0001, dated January 24, 2022, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Pharmacist, Nurse Practitioner (NP), Quality Improvement Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, Recreation Staff, Pandemic Workers, family members, and residents.

During the course of the inspection, the inspector(s) toured the home and completed the IPAC checklist, observed the provision of care and services, resident and staff interactions, resident home areas, and reviewed relevant clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **5 WN(s)**
- **3 VPC(s)**
- **2 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Medication Incident Report and Analysis Forms identified that a RPN administered medications to two different residents that were not prescribed for them.

Following the incident, one resident experienced a change in condition and was transported to the hospital. The resident was treated and returned the following day with no new doctor's orders.

There were no changes to the health condition of the other resident.

Sources: Physician's orders, electronic Medication Administration Records, progress notes and Medication Incident Report and Analysis Forms, and interviews with staff. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A Medication Incident Report and Analysis Form was started by an RPN who found medication at the bedside of a resident on the evening shift. The medications were believed to be the resident's morning medications.

The drugs were recorded as administered on the electronic Medication Administration Record (eMAR) by an RN.

An interview with the staff member, who investigated the incident, confirmed that the RN verified that they had left the medications at the resident’s bedside during the medication pass.

The resident was not administered medications in accordance with the directions as specified by the prescriber. This had the potential for the resident to experience symptoms which the medications were prescribed to treat.

Sources: Medication Incident Report and Analysis Form and eMAR for a resident and interviews with staff. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that medication incidents involving residents were

documented with a record of the immediate actions taken to assess and maintain the residents' health, and/or was reported to the resident, the resident's Substitute Decision Maker (SDM), if any, and the prescriber of the drugs.

i. A medication incident occurred when a resident was administered medications which were ordered for another resident. The incident was found two days later; however, once identified, a Medication Incident Report and Analysis Form was started.

There was no documentation of immediate actions taken to assess and maintain the resident's health nor was the medication incident reported as required.

ii. Another resident received an order to start a medication after a procedure was completed. An RPN administered the medication before starting the procedure. A Medication Incident Report and Analysis Form was completed.

There was no documentation of immediate actions taken to assess and maintain the resident's health nor was the medication incident reported as required.

iii. Another resident's morning medications were found in their room during the evening shift as reported on a Medication Incident Report and Analysis Form.

The RPN, who found the error, stated that they did not take or document any immediate actions to assess or maintain the resident's health. The RPN confirmed that the resident/SDM was not notified.

There was no documentation of immediate actions taken to assess and maintain the resident's health nor were the medication incidents reported as required.

The failure to document immediate actions taken to assess and maintain the residents' health following a medication incident or to report it to all required parties resulted in a lack of communication regarding the care provided.

Sources: Medication Incident and Analysis Forms and clinical health records for residents and interviews with staff. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review, in order to reduce and prevent medication incidents and adverse

drug reactions, and that changes and improvements identified in the review were implemented.

i. A review of the Medication Management Meeting Minutes for August 2021, identified a number of medication incidents in the second quarter of 2021.

There was no record of any changes to reduce and prevent medication incidents; however, a need to follow up and work with front line staff on documentation was noted. The Administrator/DOC confirmed that the minutes were reflective of the discussion and did not include a record of changes.

ii. A review of the Medication Management Meeting Minutes for October 2021, identified a number of medication incidents in the third quarter of 2021. There was no record of a review of the medication incidents or any changes to reduce and prevent medication incidents.

The Administrator/DOC confirmed that at the time of the meeting the participants were only aware of the number of incidents, not the specific details. There was no review of the reports or identification of changes.

The medication incidents were not fully reviewed during the October 2021 meeting as the records were not available. It was identified that the home planned to complete the review of the third quarter medication incidents at the next scheduled meeting.

The failure to review medication incidents and identify changes and improvements at quarterly evaluations had the potential for medication errors to continue.

Sources: A review of the Medication Management Meeting Minutes for August and October 2021 and interviews with staff. [s. 135. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, and the prescriber of the drugs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The licensee has failed to ensure that PSWs participated in the implementation of the IPAC program related to performing resident hand sanitizing.

The home's policy on Handwashing, stated that the evidence-based program Just Clean Your Hands (JCYH) was used for education, training, and auditing purposes. The JCYH Long-Term Care Homes (LTCH) Implementation Guide stated that "residents' hands must be cleaned before and after meals". The document, Process During Room Service, showed that all PSW staff were to sanitize all resident hands at lunch and dinner.

During lunch tray service, only two of the eight residents observed were offered hand sanitizer prior to the start their meal. No hand hygiene was offered when trays were collected.

During lunch tray service, residents were not encouraged or not provided with hand hygiene by a recreation staff as trays were delivered and collected. That same staff member assisted residents with their meal set up. They confirmed that PSWs should perform hand hygiene for all residents. A bottle of alcohol-based hand sanitizer was available on the tray cart.

The former Infection Prevention and Control (IPAC) lead confirmed that the home was following the JCYH program and expected staff to follow the program and offer or provide residents with hand cleaning before and after all meals.

The failure to perform hand hygiene for residents or encourage hand hygiene before and after meals, may have increased the risk of spread of infectious organisms.

Sources: Handwashing/Just Clean Your Hands Audit Policy, JCYH LTCH Implementation Guide, Edgewater Gardens Process During Room Service; observations at mealtimes; and interviews with staff.

B. The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to the use of personal protective equipment (PPE).

The home’s Personal Protective Equipment policy, outlined what PPE was required in each situation and the order to put on and take off the required PPE. Signs outlining this process were posted throughout the home near PPE carts.

Two nursing staff entered a resident's room who was on additional precautions. The staff put on their gloves and then their gowns before entering the room. The sign outside the room and the home's policy required staff to put on the gown first and then the gloves.

A PSW did not follow the home's PPE policy, when they were observed to put on a gown, clean and replace their eye protection before they put on a N95 mask.

Another PSW was observed taking off their PPE after they fed a resident. The staff member failed to take off their PPE correctly when they removed their gloves after their gown, mask, and eye protection. The PSW confirmed that they did not remove their PPE in the correct order.

The IPAC Lead stated that they expected staff to wear the correct PPE and follow the correct process when putting on and taking off their PPE, as shown on the signs.

The failure of staff to put on and take off PPE according to the established process may have increased the risk of spread of infectious organisms to residents and/or other staff.

Sources: Observation of staff; Personal Protective Equipment policy; interviews with staff. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was revised for a resident when their care needs changed, or care set out in the plan was no longer necessary.

A resident sustained an injury. The next day, the resident had a change in condition and required additional care from staff.

A review of the plan of care did not include the injury, their change in condition or care needs as confirmed by the Administrator/DOC.

The failure to update the resident's plan of care with the changes in their care needs had the potential for risk, if care was not provided as needed because staff were not aware of the changes.

Sources: Resident’s plan of care and records and interviews with staff. [s. 6. (10) (b)]

WN #5: 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 comply with section (s). 24 (1) 1 of the Long-Term Care Homes Act (LTCHA) in that a person, who had reasonable grounds to suspect incompetent care of a resident, failed to report the alleged incompetency immediately to

the Director in accordance with the LTCHA.

According to s. 152 (2) the licensee was indirectly responsible for staff members failing to follow subsection 24 (1).

The Administrator/DOC received an email which stated that the family of a resident questioned the competency of a staff member. The family's questions were related to the treatment of the resident and their understanding of the resident/family's care wishes.

Progress notes identified that there was a discussion about the resident's goals of care and changes were made to their advanced care directives.

The Administrator/DOC confirmed that they received the email and followed up with the staff member; however, did not report the allegations to the Director.

Failure to notify the Director of allegations of incompetent care had the potential for the Director to be unaware of the allegations and to take actions as needed.

Sources: Review of progress notes of a resident, review of email and meeting notes and interviews with staff. [s. 24. (1) 1.]

2. The licensee has failed to comply with s. 24 (1) 2 of the LTCHA in that a person, who had reasonable grounds to suspect neglect of a resident, failed to report the alleged neglect immediately to the Director in accordance with the LTCHA.

According to s. 152 (2) the licensee was indirectly responsible for staff members failing to follow subsection 24 (1).

The Administrator/DOC received an email from a RN, which identified that a resident was not provided care as scheduled by a staff member and that this was neglect.

Progress notes showed that the medical device was not changed as scheduled and that the resident needed to receive treatment.

The Administrator/DOC confirmed that they received the email and followed up with the staff member; however, did not report the allegations of neglect to the Director.

Failure to notify the Director of allegations of neglect had the potential for the Director to

be unaware of the allegations and to take actions as needed.

Sources: Review of progress notes and clinical records of a resident, review of email and follow up meeting notes and interviews with staff. [s. 24. (1) 2.]

Issued on this 28th day of January, 2022

[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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	BARBARA GROHMANN (720920), LISA VINK (168)
Inspection No. / No de l’inspection :	2022_968920_0002
Log No. / No de registre :	013005-21, 019730-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 24, 2022
Licensee / Titulaire de permis :	Haldimand War Memorial Hospital 400 Broad Street West, Dunnville, ON, N1A-2P7
LTC Home / Foyer de SLD :	Edgewater Gardens Long Term Care Centre 428 Broad Street West, Dunnville, ON, N1A-1T3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Greg Allen

To Haldimand War Memorial Hospital, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee must comply with section 131 (1) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that:

1. No drug is administered to a resident unless the drug is prescribed for them.

2. Provide or arrange for face to face training to registered nursing staff regarding safe medication practices and the process to be followed in the home if a medication incident occurs and maintain a record of this training.

Grounds / Motifs :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Medication Incident Report and Analysis Forms identified that a RPN administered medications to two different residents that were not prescribed for them.

Following the incident, one resident experienced a change in condition and was transported to the hospital. The resident was treated and returned the following day with no new doctor's orders.

There were no changes to the health condition of the other resident.

Sources: Physician's orders, electronic Medication Administration Records, progress notes and Medication Incident Report and Analysis Forms, and interviews with staff.

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

Severity: As a result of receiving drugs that were not ordered for them one resident experienced actual harm and a change in condition that required going to the hospital to receive treatment.

Scope: This non-compliance was a pattern as two of three residents inspected received medications that were not prescribed for them.

Compliance History: In the past 36 months, six Written Notifications (WN), three Voluntary Plans of Correction (VPC) and one Compliance Order (CO) to another section(s) of the legislation, which was complied, were issued to the home. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

The licensee must comply with section 135 (3) of Ontario Regulation 79/10.

Specifically, the licensee shall ensure that:

1. A quarterly evaluation is undertaken of all medication incidents that occurred in the home since the time of the last review. This evaluation shall include detecting trends, root causes and contributing factors to the incidents.

These factors are to be used to assist in determining changes and improvements to be made to reduce and prevent medication incidents.

2. The home shall maintain a record of the changes and improvements made, including when and how they were implemented.

3. Registered staff shall be provided a copy of the quarterly evaluation meeting minutes for review.

Grounds / Motifs :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review, in order to reduce and prevent medication incidents

and adverse drug reactions, and that changes and improvements identified in the review were implemented.

i. A review of the Medication Management Meeting Minutes for August 2021, identified a number of medication incidents in the second quarter of 2021.

There was no record of any changes to reduce and prevent medication incidents; however, a need to follow up and work with front line staff on documentation was noted. The Administrator/DOC confirmed that the minutes were reflective of the discussion and did not include a record of changes.

ii. A review of the Medication Management Meeting Minutes for October 2021, identified a number of medication incidents in the third quarter of 2021. There was no record of a review of the medication incidents or any changes to reduce and prevent medication incidents.

The Administrator/DOC confirmed that at the time of the meeting the participants were only aware of the number of incidents, not the specific details. There was no review of the reports or identification of changes.

The medication incidents were not fully reviewed during the October 2021 meeting as the records were not available. It was identified that the home planned to complete the review of the third quarter medication incidents at the next scheduled meeting.

The failure to review medication incidents and identify changes and improvements at quarterly evaluations had the potential for medication errors to continue.

Sources: A review of the Medication Management Meeting Minutes for August and October 2021 and interviews with staff.

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

Severity: As a result of failing to review medication incidents and identify changes to improve the system at quarterly evaluations, residents were at minimal risk of harm due to the potential for medication errors to continue.

Scope: This non-compliance was a pattern as two quarterly medication incident reviews failed to identify changes to improve the system to reduce or prevent medication errors.

Compliance History: In the past 36 months, six WN, three VPC and one CO to another section(s) of the legislation, which was complied, were issued to the home.
(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 21, 2022

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:

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

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 24th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Barbara Grohmann

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