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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
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Téléphone: (705) 564-3130
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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
Jun 23, 2020	2020_752627_0007 (A1)	023766-19, 024019-19, 001843-20, 002849-20, 007064-20, 008484-20, 008603-20	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Parry Sound East
62 Big Bend Avenue Box 400 POWASSAN ON P0H 1Z0

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

Eastholme Home for the Aged
62 Big Bend Avenue P.O. Box 400 POWASSAN ON P0H 1Z0

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

Amended by SYLVIE BYRNES (627) - (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

Compliance due dates changed.

Issued on this 23rd day of June, 2020 (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

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62 Big Bend Avenue P.O. Box 400 POWASSAN ON P0H 1Z0

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 25-29, 2020, and

June 1-5, 2020.

The following intakes were inspected during this Critical Incident System inspection:

- One Critical incident system (CIS) report related to improper transfer of a resident;

- One CIS report related to alleged resident abuse;

- Four CIS reports, related to falls; and,

- One CIS report related to a medication error.

A Follow Up inspection, #2020_752627_0008, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Manager, Pharmacist, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Custodial staff member and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health records, internal investigation documents, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director for a fall of resident #004, for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. The CIS report identified that Personal Support Worker (PSW) #120 provided care for resident #004, in a different manner than what was indicated in the resident's plan of care, which contributed to the resident sustaining a fall.

Inspector #744 reviewed resident #004’s care plan in effect at the time of the incident. The care plan indicated the need for specific interventions for dressing, transferring and personal hygiene, which were not all implemented at the time of the incident.

Inspector #744 reviewed the home’s policy titled “Care Plan”, with an effective date of August 19, 2003, which indicated that the purpose of the care plan was to provide direction to staff to meet the needs of each resident in a consistent manner.

In an interview with Inspector #744, PSW #120 indicated that at the time of the incident, resident #004 required assistance with some activities of daily living (ADL) and described what had been effective when providing the resident with care.

Inspector #744 interviewed Registered Practical Nurse (RPN) #119 who stated that resident #004 often exhibited responsive behaviours, therefore, care should have been provided in a specific away. The RPN stated that due to other factors that day, care should have been provided in a specific manner, which differed from how the care had been provided.

In an interview with Inspector #744, the Director of Care (DOC) acknowledged that the care plan was not followed.

2. The licensee has failed to ensure that resident #004 was reassessed and that their plan of care was reviewed at least every six months, and at any other time when the resident's care needs changed, or care set out in their plan was no longer necessary.

A CIS report was submitted to the Director for a fall of resident #004. Please see WN #1 for details.

Inspector #744 reviewed resident #004's care plan in effect at the time of the incident for the focus "high risk for falls". The care plan indicated that staff were to implement a specific intervention.

During multiple observations of resident #004, Inspector #744 had not observed the specific intervention in place.

Inspector #744 reviewed the home's policy titled "Care Plan", with an effective date of August 19, 2003, which indicated that care plan review and revision will be carried out when the care set out in the plan is no longer necessary or effective.

In an interview with Inspector #744, PSW #128 indicated that resident #004 no longer required that specific intervention.

Inspector #744 interviewed Registered Nurse (RN) #129 who stated that it had been many years since the resident required the specific intervention.

In an interview with Inspector #744, Resident Assessment Instrument (RAI) Coordinator #122 indicated that the intervention was no longer effective and should be removed from the resident's care plan.

In an interview with Inspector #744, the DOC stated that the care plan should be an accurate reflection of care. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A CIS report was submitted to the Director for a fall of resident #003, for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. The resident subsequently passed as a consequence of the fall.

Inspector #744 reviewed resident #003's electronic progress notes from Point Click Care (PCC) which identified the history of falls since admission, which included multiple falls in 2019-2020, as well as four falls in the previous years.

Inspector #744 reviewed resident #003's care plan for the focus of "high risk for falls" and noted that the interventions listed in the care plan for this focus and goal had been initiated one year and eight months earlier, with no new fall interventions trialed to address the resident's multiple falls, until their last fall.

During a review of the home's policy titled "Fall Prevention and Management program", effective date December 17, 2010, it identified that "If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary". The policy also included a list available equipment to assist in fall prevention and reduce injury which included: Hip protectors, hi/low beds, alarms and bed side floor cushion (mats). Inspector #744 reviewed resident #003's plan of care which did not indicate that the above equipment was trialed, except for one specific intervention after the resident's last fall.

In an interview with Inspector #744, PSW #109 indicated that residents who were at high risk for falls usually had three to four specific interventions depending on their needs.

In an interview with Inspector #744, RPN #124 indicated that resident #003 often fell after attempting specific ADLs. The RPN also indicated that one specific intervention would have benefited the resident and may have decreased the number of falls the resident sustained, had the intervention been trialed.

In an interview with Inspector #744, RAI Coordinator #122 confirmed that resident #003 had fallen frequently and that new interventions had not been trialed, except for one specific intervention. They further indicated that staff were to be involved in post falls huddles and were expected to identify patterns of falls and have different interventions trialed.

In an interview with Inspector #744, the DOC indicated that if there were any interventions trialed for resident #003, they would have been in the care plan. The DOC also indicated that if the interventions were not documented, it would be assumed that it was not done. They further indicated that assessments were made at the moment of the fall, if there was an intervention that was needed for resident #003, it would have been utilized. (744) [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 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# 002,001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director regarding allegations of neglect by

staff toward resident #002. The CIS report indicated that the staff were completing a visual round of residents and discovered resident #002 had sustained a fall.

Inspector #627 reviewed the home's investigation notes which revealed that the present shift noted that care that should have been provided on the earlier shift had not been provided.

A review by Inspector #627 of a specific type of assessment which indicated that the resident required a specific level of assistance with ADLs.

A review of resident #002's care plan in effect at the time of the injury, indicated the specific level of care that the resident required.

Inspector #627 reviewed resident #002's flow-sheet which indicated what care had been provided and noted that there was no documentation for the specific shift on a specific date, when the incident occurred.

Inspector #627 reviewed three "shift routine guidelines" for the shift when resident #002 sustained a fall, which indicated that staff was to provide a certain type of care during a certain time frame.

Inspector #627 reviewed the home's policy titled "Prevention of Abuse and Neglect", last reviewed September, 2019, which defined neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #627 interviewed PSW #130 who stated that they had worked during that shift. PSW #130 could not recall providing the specific care to resident #002.

Inspector #627 interviewed PSW #104 and #106, in separate interviews. Both PSWs could not recall providing the specific care to resident #002.

Inspector #627 interviewed RPN #108 who stated that the specific care was provided to the residents on this specific shift, unless a resident specified a different time. The RPN #108 stated that they had not been told that resident #002 had not been provided with the specific care, or they would have reported it to the oncoming shift to ensure the specific care was provided to the resident at the beginning of the following shift. .

Inspector #627 interviewed the Assistant Director of Care (ADOC), who acknowledged that there was inaction on the part of the PSWs which jeopardized resident #002's health and well-being, and that there was a failure to communicate the need to render care to resident #002 to the oncoming shift. [s. 20.]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director in regard to an unsafe transfer. The CIS report indicated that resident #005 had been unsafely assisted with a transfer.

Inspector #627 reviewed resident #005's care plan in effect at the time of the incident for the focus of toileting which instructed how the resident was to be transferred.

Inspector #627 reviewed the home's policy titled "Minimal Lift and Transfers", effective date July 2014, which indicated that "all mechanical lifts will be operated with two staff members to promote safety of staff and residents".

During separate interviews with PSW #106, 109, and RN #110, they stated that the home's policy was to have two staff members assisting for all mechanical transfers. PSW #106 stated that "we need two staff to operate mechanical lifts; one person is not enough. One person operates the sling and lift, and the other person is needed to assist the resident".

Inspector #627 interviewed PSW #107 who acknowledged that they had not followed the home's policy.

Inspector #627 interviewed the DOC who stated that the home's policy was to be followed to ensure the safety of the residents and staff members. [s. 36.]

Issued on this 23rd day of June, 2020 (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 SYLVIE BYRNES (627) - (A1)
Inspection No. / No de l'inspection :	2020_752627_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	023766-19, 024019-19, 001843-20, 002849-20, 007064-20, 008484-20, 008603-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 23, 2020(A1)
Licensee / Titulaire de permis :	The Board of Management for the District of Parry Sound East 62 Big Bend Avenue, Box 400, POWASSAN, ON, P0H-1Z0
LTC Home / Foyer de SLD :	Eastholme Home for the Aged 62 Big Bend Avenue, P.O. Box 400, POWASSAN, ON, P0H-1Z0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve Piekarski

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 The Board of Management for the District of Parry Sound East, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be in compliance with s. 6. (7) of the LTCHA. Specifically the licensee must:
a) Ensure resident #004's and all other resident's plans of care are followed, specifically, but not limited to personal care and monitoring checks.
b) Ensure resident #004's and all other resident's plans of care are followed specifically, but not limited to falls prevention interventions.
c) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director for a fall of resident #004, for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. The CIS report identified that Personal Support Worker (PSW) #120 provided care for resident #004, in a different manner than what was indicated in the resident's plan of care, which contributed to the resident sustaining a fall.

Inspector #744 reviewed resident #004's care plan in effect at the time of the incident. The care plan indicated the need for specific interventions for dressing, transferring and personal hygiene, which were not all implemented at the time of the incident.

Inspector #744 reviewed the home's policy titled "Care Plan", with an effective date

of August 19, 2003, which indicated that the purpose of the care plan was to provide direction to staff to meet the needs of each resident in a consistent manner.

In an interview with Inspector #744, PSW #120 indicated that at the time of the incident, resident #004 required assistance with some activities of daily living (ADL) and described what had been effective when providing the resident with care.

Inspector #744 interviewed Registered Practical Nurse (RPN) #119 who stated that resident #004 often exhibited responsive behaviours, therefore, care should have been provided in a specific away. The RPN stated that due to other factors that day, care should have been provided in a specific manner, which differed from how the care had been provided.

In an interview with Inspector #744, the Director of Care (DOC) acknowledged that the care plan was not followed.

The severity of this issue was determined to be a level three, as there was actual harm to the resident in the home. The scope of the issue was a level one as it was isolated to one resident. The home had a level three compliance history, as they had previous non-compliance with this section of the LTCHA which included:
- Voluntary plan of correction (VPC) was issued during a Critical Incident System (CIS) inspection, #2018_671684_0031, on December 2018;
- VPC was issued during a Resident Quality Inspection (RQI), #2017_638609_0016, on July 7, 2017.

(744)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 07, 2020(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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be in compliance with s. 6 (10) (c) of the LTCHA.
Specifically, the licensee must:
a) Develop and implement a written procedure to ensure that all residents' plans of care are reviewed and revised when the care set out has not been effective, and to ensure that different approaches are considered in the revision of the plan of care, specifically, but not limited to falls prevention interventions.
b) Maintain a record of the actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A CIS report was submitted to the Director for a fall of resident #003, for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. The resident subsequently passed as a consequence of the fall.

Inspector #744 reviewed resident #003's electronic progress notes from Point Click Care (PCC) which identified the history of falls since admission, which included

multiple falls in 2019-2020, as well as four falls in the previous years.

Inspector #744 reviewed resident #003's care plan for the focus of "high risk for falls" and noted that the interventions listed in the care plan for this focus and goal had been initiated one year and eight months earlier, with no new fall interventions trialed to address the resident's multiple falls, until their last fall.

During a review of the home's policy titled "Fall Prevention and Management program", effective date December 17, 2010, it identified that "If the interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary". The policy also included a list available equipment to assist in fall prevention and reduce injury which included: Hip protectors, hi/low beds, alarms and bed side floor cushion (mats). Inspector #744 reviewed resident #003's plan of care which did not indicate that the above equipment was trialed, except for one specific intervention after the resident's last fall.

In an interview with Inspector #744, PSW #109 indicated that residents who were at high risk for falls usually had three to four specific interventions depending on their needs.

In an interview with Inspector #744, RPN #124 indicated that resident #003 often fell after attempting specific ADLs. The RPN also indicated that one specific intervention would have benefited the resident and may have decreased the number of falls the resident sustained, had the intervention been trialed.

In an interview with Inspector #744, RAI Coordinator #122 confirmed that resident #003 had fallen frequently and that new interventions had not been trialed, except for one specific intervention. They further indicated that staff were to be involved in post falls huddles and were expected to identify patterns of falls and have different interventions trialed.

In an interview with Inspector #744, the DOC indicated that if there were any interventions trialed for resident #003, they would have been in the care plan. The DOC also indicated that if the interventions were not documented, it would be assumed that it was not done. They further indicated that assessments were made at the moment of the fall, if there was an intervention that was needed for resident #003, it would have been utilized. (744)

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

The severity of this issue was determined to be a level three, as there was actual harm to the resident, in the home. The scope of the issue was a level one as it was isolated to one resident. The home had a level two compliance history, to a different subsection of the LTCHA. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 07, 2020(A1)

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:

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
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

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
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 23rd day of June, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SYLVIE BYRNES (627) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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