Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2018;	2017_678680_0019 (A1)	022493-17	Complaint

Licensee/Titulaire de permis

FAIRVIEW MENNONITE HOME
515 Langs Drive CAMBRIDGE ON N3H 5E4

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

FAIRVIEW MENNONITE HOME
515 LANGS DRIVE CAMBRIDGE ON N3H 5E4

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

TRACY RICHARDSON (680) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The report has amended to correct a year and a time.

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 31 day of January 2018 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

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

TRACY RICHARDSON (680) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 1 and 2, 2017.

Complaint inspection:

Log #022493-17, IL #53037-LO, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Previous Director of Care, Registered Practical Nurses, Registered Nurses, Personal Support Workers, a dietary aide, and a family member.

The inspector(s) also made observations of residents, and activities and care of residents. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Reporting and Complaints

During the course of this 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	Legendé 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. 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 :

(A1)
1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10, s. 30(1) states that the following shall be complied with in respect of each of the organized programs required under each of the interdisciplinary programs under section 48 of the Regulation: (1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Under Ontario Regulation 79/10, s. 48(1), every licensee shall ensure that the following interdisciplinary program is developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Ontario Regulation 79/10, s. 49(1) states the following: The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Review of the home's policy titled Falls Prevention, dated February 2016, stated:
"Post fall management-refer to algorithm, the interdisciplinary team will:
1. Initiate Head injury routine and assess the resident's level of consciousness and

any potential injury associated with the fall if they received any head trauma.
2. Notify the attending Physician and ensure immediate treatment after the fall if required. Notify POA as necessary"

Review of the home's policy titled Head Trauma, review date, June 2015, stated:
"That any resident who suffer trauma to his/her head:
1. Laceration to head
2. Loss of consciousness
3. An obvious bump to head
OR is suspected of receiving trauma to his/her head shall be assessed by the registered nurse prior to being moved.
Procedure:
A) a neurological assessment of resident with trauma shall include head injury routine (HIR)
1) level of consciousness (LOC)
2) orientation
3) response to commands or painful stimuli
4) motor and sensory function in all extremities (strength of grips bilaterally)
5) pupil size and reaction
6) complete vital signs (blood pressure, pulse, respiration) FREQUENCY; at time of injury repeat in 1 hour then q2h x 4 times then if stable every shift x72 hours-if any indication of decline in status, physician must be notified or transfer to ER
B) PN-F or PN-FI entered into the computer
C)Family and/or next of kin shall be advised of all injuries to the head
D)Physician to be notified at earliest possible opportunity
E) Vital signs will be entered into computer each time taken so history is available for comparison"

A) Review of a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) was related to a specified resident who had sustained a fall on a specific date.

A progress note with specified date and time stated the specific resident had an unwitnessed fall. The resident complained of pain to specific area. The next progress note stated resident complained about the pain in the same area. There was no documentation of motor or sensory function to the lower extremities. The next progress note was recorded on a specified date and time was "that vitals monitored per head injury routine (HIR) and documented," the progress note stated that the resident's hand grips were equal and strong and pupils were equal and

reactive.

A progress noted on a specific date stated that the family had been notified and requested transfer to the hospital. There was no other documentation regarding family notification prior to this notation after the fall.

Review of point click care documentation of vital signs recorded after the initial assessment when the specified resident fell, were documented on a different date and time. Progress notes showed that from a specific date and time to another date and time there was no documentation to support that vital signs had been monitored.

Progress notes during a specified time frame showed there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored.

In an interview, a registered staff member stated that the fall occurred. The registered staff member stated that HIR were usually marked on a sheet of paper to assist in tracking. The registered staff member stated that HIR for the specific resident had been initiated after the fall and report to the oncoming nurse was completed. The registered staff member stated that the resident had complained of pain in a specified area.

In an interview a registered staff member stated that they had completed the HIR on the specified resident when they arrived and had done so every two hours. The registered staff member stated that if there was unusual behaviours they would have charted those changes in progress notes. In a telephone interview the registered staff member shared that they had checked the resident's pupils and hand grips when they completed the vital signs during the night. The registered staff member shared it was a nursing judgement to wake residents during the night and that they did arouse this resident for checks throughout the night and when they left in the morning the resident did respond when wakened.

In an interview the previous Director of Care (PDOC) acknowledged that the HIR according to progress notes would not have complied with the HIR policy and procedure. The PDOC stated that there was a sheet that the staff would use to document HIR on. A review of the chart with PDOC was completed and PDOC acknowledged that the HIR sheet was not present in the chart.

B) Another resident experienced an unwitnessed fall on a specific date and time. Registered staff initiated a head injury routine (HIR) for the resident.

A progress note on a specific date and time stated the resident had an unwitnessed fall and had nonverbal signs of pain in their back. The note stated the resident was exhibiting a change in their condition. The note added that the resident's pupils were equal and reactive and both grips equally strong.

A progress note on a different date stated the resident was assessed at a specific time which was earlier than this time. The vitals that were listed in this charting were the same vital signs charted on the "new resident or readmission vitals" sheet at a specific time. In the note it stated "pupils equal and reactive to light (PEARL) and grips equal. Resident was sleeping when writer went to assess."

Review of a vital sign sheet tilted "New Resident or Readmission" had a note written on the form that stated “head injury routine, fall" on a specified time and date, showed vitals not taken at a specific hour as the resident was sleeping. The form had no signatures to indicate who had done the assessments. On the side of the page at two specific times it was marked pupils equal and reactive (PEARL) and grips equal. No other documentation regarding neurological assessment was present on the form. On this form vital signs were shown as taken at a specific time.

Progress notes showed that over a five hour and fifteen minute period on a specific date, there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored. There were no vital signs recorded on that same date over a four hour period..

C) Another resident experienced an unwitnessed fall on a specific date and time. Registered staff initiated a head injury routine (HIR) for the resident and documented that a specific injury had been noted.

Review of a vital sign sheet tilted "New Resident or Readmission," with the initiation date specified, showed that; there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored consistently. The pupils were recorded as being reactive two separate

specified times. Grips were noted to be strong on two specified time frames.

Progress notes showed that on a specific date and for a specified number of hours there was no documentation to support that; level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored. On a specific date and time the only neurological assessment was that resident was cooperative and pupils were equal and reacting. The next recorded neurological assessment was done on another date and time which stated "grips strong and equal; PEARL." Vital signs had been taken consistently.

In an interview a registered staff member stated that the HIR is to be followed as per policy. The registered staff member stated that there was a sheet they used and that sometimes the HIR was on the paper, and sometimes it was in the point click care documentation. The registered staff member acknowledged that the HIR sheet did not have a signature of who did the assessment. The registered staff member shared that the sheet should not be used and that the information should be in the computer.

In an Interview another registered staff member stated that if a resident was sleeping they would always wake them up to do the vitals and check them.

In an interview another registered staff member shared that neurological checks involved hand grips, pupils, level of consciousness, and if the resident could follow directions as compared to their responses prior to the fall. The registered staff shared that they just check the upper body extremities for strength and not the strength of the legs during those routine checks. The registered staff member shared that the registered staff document in the computer and that they also have a HIR sheet they can use.

In an interview the Director of Care (DOC) acknowledged that the charting showed they did not meet the policy by charting electronically. The DOC acknowledged that the HIR was inconsistent in the documentation. The DOC stated that the expectation is that resident's should be awakened to have the HIR followed.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread. The home had a level 3 history of non-compliance with this section of the Act that included: voluntary plan of correction (VPC) issued August 10, 2015 (2015_258519_0028) [s. 8. (1) (a),s. 8. (1) (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:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints received concerning the care of a resident or the operation of the home was immediately forwarded to the Director.

Review of a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) was related to a resident who had sustained a fall.

An email was sent to the home on a specified date to the previous Director of Care

(PDOC). In the email the family member had the following complaints regarding care issues.

Review of the complaint log , showed the response was to "report to MOHLTC in CIS report of concern."

Review of the Critical Incident System (CIS) did not show a submission for this complaint. The CIS related to the fall was submitted on a specific date and time. The CIS contained the following the statement "family raised concerns about not being notified at the time of the fall." There was no other documentation about the other concerns mentioned within this report.

Review of the Ministry of Health and Long-Term Care (MOHLTC) data base showed no documentation that a report was sent to the Director regarding a complaint concerning the care of the specified resident.

In an interview the previous Director of Care (PDOC) stated that a report was not sent to the MOHLTC regarding this complaint as these issues had been dealt with previously. PDOC stated they did not feel there could be resolution, and that due to the fact they had been addressed prior to this that a report to the Director did not need to be done.

In an interview the Administrator stated that looking back now it was reportable. The administrator acknowledged it was not reported as per the PDRC statement regarding this.

The licensee has failed to ensure that any written complaints received concerning the care of a resident or the operation of the home was immediately forwarded to the Director.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was isolated. The home has a history of unrelated noncompliance. [s. 22. (1)]

Issued on this 31 day of January 2018 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : TRACY RICHARDSON (680) - (A1)

Inspection No. / No de l'inspection : 2017_678680_0019 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 022493-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jan 31, 2018;(A1)

Licensee / Titulaire de permis : FAIRVIEW MENNONITE HOME
515 Langs Drive, CAMBRIDGE, ON, N3H-5E4

LTC Home / Foyer de SLD : FAIRVIEW MENNONITE HOME
515 LANGS DRIVE, CAMBRIDGE, ON, N3H-5E4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jim Williams

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 FAIRVIEW MENNONITE HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the homes' fall prevention and head trauma policy is complied with specifically but not limited to the current procedures outlined in the head trauma policy including:
A) a neurological assessment of resident with trauma shall include head injury routine (HIR)
1) level of consciousness (LOC)
2) orientation
3) response to commands or painful stimuli
4) motor and sensory function in all extremities (strength of grips bilaterally)
5) pupil size and reaction
6) complete vital signs (blood pressure, pulse, respiration) frequency; at time of injury repeat in one hour then every four hours for four times then if stable every shift for 72 hours-if any indication of decline in status, physician must be notified or transfer to ER
B) PN-F or PN-FI entered into the computer
C)Family and/or next of kin shall be advised of all injuries to the head

Grounds / Motifs :

(A1)

1. 1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

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"That any resident who suffer trauma to his/her head:
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OR is suspected of receiving trauma to his/her head shall be assessed by the registered nurse prior to being moved.

Procedure:
A) a neurological assessment of resident with trauma shall include head injury routine
(HIR)
1) Level of consciousness (LOC)
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5) Pupil size and reaction
6) Complete vital signs (blood pressure, pulse, respiration)
FREQUENCY; at time of injury repeat in 1 hour then q2h x 4 times then if stable every shift x72 hours-if any indication of decline in status, physician must be notified or transfer to ER
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and time there was no documentation to support that vital signs had been monitored.

Progress notes during a specified time frame showed there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored.

In an interview, a registered staff member stated that the fall occurred. The registered staff member stated that HIR were usually marked on a sheet of paper to assist in tracking. The registered staff member stated that HIR for the specific resident had been initiated after the fall and report to the oncoming nurse was completed. The registered staff member stated that the resident had complained of pain in a specified area.

In an interview a registered staff member stated that they had completed the HIR on the specified resident when they arrived and had done so every two hours. The registered staff member stated that if there was unusual behaviours they would have charted those changes in progress notes. In a telephone interview the registered staff member shared that they had checked the resident's pupils and hand grips when they completed the vital signs during the night. The registered staff member shared it was a nursing judgement to wake residents during the night and that they did arouse this resident for checks throughout the night and when they left in the morning the resident did respond when wakened.

In an interview the previous Director of Care (PDOC) acknowledged that the HIR according to progress notes would not have complied with the HIR policy and procedure. The PDOC stated that there was a sheet that the staff would use to document HIR on. A review of the chart with PDOC was completed and PDOC acknowledged that the HIR sheet was not present in the chart.

B) Another resident experienced an unwitnessed fall on a specific date and time. Registered staff initiated a head injury routine (HIR) for the resident.

A progress note on a specific date and time stated the resident had an unwitnessed fall and had nonverbal signs of pain in their back. The note stated the resident was exhibiting a change in their condition. The note added that the resident's pupils were equal and reactive and both grips equally strong.

A progress note on a different date stated the resident was assessed at a specific time which was earlier than this time. The vitals that were listed in this charting were the same vital signs charted on the "new resident or readmission vitals" sheet at a specific time. In the note it stated "pupils equal and reactive to light (PEARL) and grips equal. Resident was sleeping when writer went to assess."

Review of a vital sign sheet tilted "New Resident or Readmission" had a note written on the form that stated “head injury routine, fall" on a specified time and date, showed vitals not taken at a specific hour as the resident was sleeping. The form had no signatures to indicate who had done the assessments. On the side of the page at two specific times it was marked pupils equal and reactive (PEARL) and grips equal. No other documentation regarding neurological assessment was present on the form. On this form vital signs were shown as taken at a specific time.

Progress notes showed that over a five hour and fifteen minute period on a specific date, there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored. There were no vital signs recorded on that same date over a four hour period.

C) Another resident experienced an unwitnessed fall on a specific date and time. Registered staff initiated a head injury routine (HIR) for the resident and documented that a specific injury had been noted.

Review of a vital sign sheet tilted "New Resident or Readmission," with the initiation date specified, showed that; there was no documentation to support that level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored consistently. The pupils were recorded as being reactive two separate specified times. Grips were noted to be strong on two specified time frames.

Progress notes showed that on a specific date and for a specified number of hours there was no documentation to support that; level of consciousness, orientation, response to commands and painful stimuli, motor and sensory function in all extremities, pupil size and reaction had been monitored. On a specific date and time the only neurological assessment was that resident was cooperative and pupils were equal and reacting. The next recorded neurological assessment was done on another date and time which stated "grips strong and equal; PEARL." Vital signs had

been taken consistently.

In an interview a registered staff member stated that the HIR is to be followed as per policy. The registered staff member stated that there was a sheet they used and that sometimes the HIR was on the paper, and sometimes it was in the point click care documentation. The registered staff member acknowledged that the HIR sheet did not have a signature of who did the assessment. The registered staff member shared that the sheet should not be used and that the information should be in the computer. In an Interview another registered staff member stated that if a resident was sleeping they would always wake them up to do the vitals and check them.

In an interview another registered staff member shared that neurological checks involved hand grips, pupils, level of consciousness, and if the resident could follow directions as compared to their responses prior to the fall. The registered staff shared that they just check the upper body extremities for strength and not the strength of the legs during those routine checks. The registered staff member shared that the registered staff document in the computer and that they also have a HIR sheet they can use.

In an interview the Director of Care (DOC) acknowledged that the charting showed they did not meet the policy by charting electronically. The DOC acknowledged that the HIR was inconsistent in the documentation. The DOC stated that the expectation is that resident's should be awakened to have the HIR followed.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread. The home had a level 3 history of non-compliance with this section of the Act that included: voluntary plan of correction (VPC) issued August 10, 2015 (2015_258519_0028) [s. 8. (1) (a),s. 8. (1) (b)]

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

(680)

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

Feb 22, 2018

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 31 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TRACY RICHARDSON

Ontario

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Service Area Office / Bureau régional de services : London